AGING IN WESTERN SOCIETIES

AGING IN WESTERN SOCIETIES

EDITED BY

Ernest W. Burgess



Library of Congress Catalog Number 60-5465

THE UNIVERSITY OF CHICAGO PRESS, CHICAGO 37
Cambridge University Press, London, N.W. 1, England
The University of Toronto Press, Toronto 5, Canada

© *1960 by The University of Chicago. Published 1960*
Composed and printed by
THE UNIVERSITY OF CHICAGO PRESS
Chicago, Illinois, U.S.A.

Foreword

The Gerontological Society, Inc., like other scientific organizations brings together research investigators who have knowledge of the growing edges of their sciences and an awareness of the emerging needs of their fields It was just such a circumstance that led the Society in 1955 to establish a committee to consider the pressing question of how to increase the number of university and college teachers equipped to train others in the psycholog ical and social aspects of aging Initial consideration of the problem by the com mittee made it evident that far more would be required to accomplish this end than merely convening a representative group of educators to propagandize the need and affirm their intentions to give more in structional emphasis to individual and societal components of aging The newness and unorganized state of knowledge about psychosocial aging the breadth of the sub ject matter to be covered and the difficul ties of introducing a new field of study and inquiry into the established academic struc ture were problems clearly requiring a comprehensive and creative approach and the investment of the thinking of *scholars* from a number of disciplines Accordingly, with the assistance of a grant from the National Institute of Mental Health [1] the committee convened a working conference of distinguished students of aging in Palm Beach Florida in July, 1956 to explore methods and make plans for meeting the need for training of scientific and profes sional personnel in social gerontology

At this conference a multiuniversity training project in social gerontology was de signed, an executive committee was se lected, the director of the project was named and plans for an Inter University Council in Social Gerontology representing the sixteen participating universities were drawn up Subsequently, grants in support of the project were made by the National Institutes of Health[2] to the University of Michigan, Institute for Human Adjust ment, Division of Gerontology, which es tablished the Inter University Training In stitute in Social Gerontology in January, 1957, to administer the program

Thus began what was destined to be the arduous twin tasks of *developing* and shaping a new scientific field of social gerontology, the subject matter for which was almost momentarily unfolding, and then of introducing the newcomer to the scientific and academic communities To accomplish these ends two major lines of action were *undertaken* The first and basic to the field of social gerontology as a proper area of education and research, was the collection, organization, and publica tion of existing scientific knowledge in the psychological and social aspects of aging to provide comprehensive reference works for use by educators in the training of students for teaching service, and research in aging The second was to provide through summer institutes intensive post graduate training for established univer *sity and college faculty* members in the psychological and social sciences and al

[1] Grant No 3M 9114

[2] National Institute of Mental Health Grant No 3M 9118 and National Heart Institute Grant No HTS 5205

lied fields By these means, the Inter University Council mobilized the most distinguished and sophisticated scholars in aging to delineate the field of social gerontology, *to develop teaching tools*, and to offer instruction to a total of seventy five faculty members selected for their interest in and potential for advancing in the field

It was *originally intended* that a single handbook of psychosocial gerontology would be prepared In structuring the field of aging however, it became evident that somewhat different foci were required to *provide* the emphasis and perspectives *which would make the technical summaries* equally useful to those concerned with individual aging and those involved with the nature of social aging and its impacts on *the individual and society* Thus two comprehensive reference works have been produced to enable maximum use of the materials

One of the two *Handbook of Aging and the Individual Psychological and Biological Aspects*, was done under the able editorship of James E Birren whose position as chief of the Section on Aging of the National Institute of Mental Health made *him the natural choice of the Inter University* Council to undertake the creative task of bringing about an orderly conceptualization of the field of human aging and of giving oversight to the preparation of the technical summaries of pertinent research In these tasks he has given a brilliant account of himself

The second of the two companion books was the volume *Handbook of Social Gerontology Societal Aspects of Aging* The Council considered none other than Clark Tibbitts for its editor because of his long apprenticeship *on the national scene* as pioneer in social gerontology and because it was he who first glimpsed its potentials for providing a rational approach to aging as a positive force in American life In 1954 he introduced the term 'social gerontology into the literature when he used it in a review of the newly published *Older People* by Ruth Albrecht and Robert J Havighurst The *Handbook* is testimony of the depth and definitiveness of his encyclopedic knowledge of aging and of his skill in organizing it into a meaningful whole Under his effective direction the outstanding authorities who contributed to the book offer a dynamic view of the emerging field of social gerontology

Believing that social gerontology in the United States could be better understood if seen against a background of other cultural groups that had experienced the phenomenon of aging at an earlier date the Council planned for a third book which would offer a review of major trends and developments in aging in several countries of western Europe and Great Britain This volume *Aging in Western Societies A Survey of Social Gerontology*, was prepared under the editorship of Professor Ernest W Burgess There could have been no more fortuitous circumstance than to have had *Dr Burgess available to undertake this* assignment Having achieved one of the most distinguished scientific careers in the United States prior to his retirement as professor and chairman of the Department of Sociology at the University of Chicago he brought to the project a perspective and sensitivity refined by years of study research and experience Thus he was able to give meaning to the social scene as observed in the various countries and to offer guidance to the contributors in relating these data to current trends in the United States

As director of the Inter University Training Project in Social Gerontology I want to express my thanks not only to the editors of the three books but also to the *sixty or more contributors* to the volumes To the members of the Executive Committee and the Inter University Council I am indebted for their continued support dedication and long hours of work which made possible the achievement of the objectives of the project The sixteen univer

sities sponsoring the project have been well represented and can take pride in the contribution which their co-operative effort has made to scientific thinking and to the advancement of the understanding and welfare of the older people of our country

ANN ARBOR MICHIGAN
July 29 1960

WILMA DONAHUE

INTER UNIVERSITY TRAINING INSTITUTE IN SOCIAL GERONTOLOGY

Director WILMA DONAHUE
University of Michigan

Assistant Project Director HAROLD L ORBACH
University of Michigan

EXECUTIVE COMMITTEE

JOHN E ANDERSON
University of Minnesota
JAMES E BIRREN
National Institute of Mental Health
ERNEST W BURGESS
University of Chicago
EWALD W BUSSE M D
Duke University
ROBERT J HAVIGHURST
University of Chicago
WOODROW W MORRIS
State University of Iowa
CLARK TIBBITTS
United States Department of Health Education and Welfare
IRVING L WEBBER
University of Florida
RICHARD C WILCOCK
University of Illinois

INTER UNIVERSITY COUNCIL

JOHN S ALLEN
University of Florida
JOHN E ANDERSON
University of Minnesota
HARRY W BRAUN
University of Pittsburgh
JOSEPH H BRITTON
Pennsylvania State University
MARION E BUNCH
Washington University (St Louis)
FEDELE F FAURI
University of Michigan
ROBBEN W FLEMING
University of Illinois
EUGENE A. FRIEDMANN
University of Wisconsin
HERBERT C HUNSAKER
Purdue University
HAROLD E JONES
University of California
DONALD P KENT
University of Connecticut
RAYMOND G KUHLEN
Syracuse University
WOODROW W MORRIS
State University of Iowa
BERNICE L. NEUGARTEN
University of Chicago
LLOYD SAVILLE
Duke University
GORDON F STREIB
Cornell University

Preface

This volume is a survey of the problems of older persons and of the solutions for their welfare adopted by societies of Western culture It attempts to picture the economic and social trends which created the modern problems of aging in industrial societies It also presents the policies and the programs which have been developed by several European nations to promote the welfare of aging people

The problems facing older people in all societies of Western culture are similar They differ mainly in degree and in the extent and in the ways in which they are being met These problems are inequality of opportunity for employment, inadequate income for livelihood and social living, unsuitable housing unmet needs for special services insufficient provision for physical and mental health stresses and strains in changing family relations, general lack of meaningful activities for retirement, and paucity of significant research on the social and psychological aspects of aging

The White House *Conference* on Aging (January, 1961) is having a tremendous impact upon the movement for the welfare of the aging in the United States There is a great humanitarian motivation behind it But sentiment, no matter how noble, is not enough There needs to be rational guidance to prevent costly mistakes in recommendations and in action

This volume aims to provide the perspective of European experience to help in guiding the welfare movement for the aging in the United States This perspective is essential for understanding and coping with the situations now facing older people in Western societies The nature of aging, the problems of older people, and the social action for their welfare will be presented in the context of the three main dimensions of social change (1) the *economic trends* of the nineteenth and twentieth centuries, (2) the resulting changes in the *socioeconomic structure* of society, and (3) the *cultural differences* which have developed among different countries

These three dimensions of social change will be analyzed as they affect the problems of the aging population and social action for the welfare of older people

1 *The economic dimension*—The basic economic trend of the past fifteen decades in Europe has been the industrialization of the economy and the urbanization of society Industrialization and urbanization have proceeded at an ever increasing tempo At first the United States lagged behind European countries in industrial and urban growth Recently, this country has forged ahead of the other nations of the Old World in its economic and technological development

This early initial lag and later rapid forward thrust in economic and industrial growth resulted in the backwardness of the United States in meeting the needs of older persons who were trapped in the vortex of the acceleration of economic change

2 *The societal d*[illegible]

zation [illegible]

and u[illegible]

society [illegible] cohesive extended family and its component nuclear family before the industrial revolution had been in practically all *societies* the unit of the production of

information and materials for their respective chapters The editor wishes to express the gratitude of the authors to our European colleagues for the time they gave in conferences, in arranging appointments, and in reading and criticizing the different chapters and for contributing statements and case studies incorporated in this volume

The editor gratefully acknowledges the help he received by way of advice, constructive suggestions, and approval of the selection of countries for the survey of Western societies and the outline of the volume from the Inter University Council of the Institute and especially from his colleagues on the Executive Committee—Wilma Donahue, chairman, John E Anderson, James E Birren, Ewald W Busse, M.D, Woodrow W Morris, Bernice L Neugarten, Clark Tibbitts, Irving L Webber, and Richard C Wilcock

Grateful acknowledgments are also made [illegible] Coons and Harold Orbach, for assuming the task of the major responsibility for checking the data, for proofreading, and for the preparation of the Index.

E W B

goods and services Both this large kinship grouping dominated by a patriarch and the small semipatriarchal family lost the age-long function of economic production Fathers, mothers, and older and even younger children no longer had their work in the home or in the family shop They went to labor for an employer in the factories which displaced the home in the production of goods

Older persons were more and more left stranded in this period of economic transition In the cities their children were less and less able to accommodate aging parents in their homes or to give them other financial assistance From 1900 to 1950 in the United States and some other countries the proportion of grandparents doubled, while the average number of adult children decreased

3 *The cultural dimension* —These economic and societal changes have occurred and are continuing in all countries of Western culture They have, however, proceeded at a different pace and often in somewhat different forms in the various nations Nearly every country has pioneered in some outstanding development This fact makes possible and desirable the drawing of cross-cultural comparisons between the different countries Thus western Europe provides an unintended laboratory in social gerontology

Finally, new organizational structures developed for the economic support of older persons Old age insurance pensions and public assistance were instituted to rescue them from destitution, from growing insecurity in an industrial society, and from the hazards of independence upon the care and aid of their children and other relatives

This volume, accordingly, will consider all three dimensions of the factors affecting the welfare of the aging as it describes and analyzes the economic and social trends and the present status and problems of the aging in selected western European societies

The book is divided into three parts Part I is composed of chapters by different authorities in the field of social gerontology Background data on representative western European countries are presented in chapter i Chapters ii–ix describe the various policies, programs, and activities that have been developed for the welfare of older people Chapter x surveys the basic and applied research on the psychological and social aspects of aging in progress in various countries of western Europe Chapter xi analyzes the policies and programs from the standpoint of their applicability as guideposts to American planning for the welfare of the aging

Part II is devoted to "Case Studies." These cases, over half of which were prepared by Europeans, were selected for their current interest in describing certain pioneering projects significant for American consideration for providing insight into human relations in cultures different from our own or for documenting in detail material presented in Part I

Part III contains fifteen statistical tables of data on the economic and social trends affecting older people and on the characteristics of the aging population They make possible significant and interesting comparisons between the more and the less industrially developed countries of western Europe (including both Communist and non Communist countries) and with four non European industrial countries and with four underdeveloped countries

In the preparation of the various chapters of this volume the authors have been fortunate in having the generous and valuable co-operation of European gerontologists Our indebtedness to them is only partially indicated by the acknowledgment at the beginning of each chapter

All the authors of chapters except Dr Hauser and Drs Vera and Jerome Peterson attended the fourth International Congress of Gerontology held in Merano and Venice, Italy, in July, 1957 During the week before the Congress they took part in the Seminar on the Social Health of the Aging in the United States and Europe which enabled them to make contacts with the leading European gerontologists In addition, they spent some weeks visiting different European countries and gathering

Contents

PART ONE

PART TWO

Selected Case Studies

PART THREE

Selected Statistical Tables

PART ONE

I

Aging in Western Culture

ERNEST W BURGESS

I Introduction

The purpose of this volume is to present a picture of aging in selected countries of Western culture Its aim is threefold First it seeks to describe the status and problems of the aging in these countries Second it attempts to portray the course of social action for the welfare of the aging Third it endeavors to compare the developments in European countries with those in the United States and so far as feasible to assess the value of their experience for American adoption adaptation or rejection

A Criteria of Western Cultures

What are the criteria by which Western cultures may be differentiated from those of other peoples?

1 *Industrialization and the growth of cities* is the first and most obvious characteristic. Industrialized countries like France Italy the Netherlands Sweden the United Kingdom West Germany and the United States whatever the differences among them are easily distinguished from such economically underdeveloped countries as Mexico Brazil Egypt and India which have a predominantly rural population With the growth of cities there has also developed the urban way of life

2 *The rise of science and technology* although less apparent is the basic characteristic of Western culture upon which industrialization and urban life depends We are now living in the atomic era with unlimited possibilities of future developments that will affect the health activities and welfare of all age groups

3 *Medical science and the prolongation of life* are farthest advanced in countries of Western culture The conquest of diseases and the reduction in morbidity and mortality have been greatest in infancy, childhood and early and middle adult life Prospects however, are bright for the victory of medical science in combating the diseases accompanying the later years of life

4 *The growth of democracy* is a common characteristic of Western cultures This includes not only universal suffrage and the guaranties of free speech free press and freedom of movement and of association but also industrial democracy

5 *The development of social gerontology* or the science of aging in its psychological and social aspects is a phenomenon of Western culture It is a recognition of the concern of industrialized countries with the welfare of their aging population Even more it is a realization that social action on behalf of the aging should be based on research not only of the biological but also of the psychological and social aspects of aging

B Selection of Countries

It is not feasible to include in this survey of social gerontology all the countries

cording to a biological criterion of aging For all males at birth the average life-expectancy for thirteen European countries of Western culture is 65 years For females it is somewhat higher In other words half of all males live beyond their sixty fifth birthday The other half die before reaching this age All living to be 65 and over have surpassed their life-expectancy at birth. They are living as the popular expression phrases it on borrowed time

In the future we undoubtedly will have a better criterion than that of chronological age Havighurst (1959) has proposed a sociological definition of aging in terms of reduction in social competence Even if we use chronological age it is evident that it may be desirable for some purposes to shift it earlier as in the case of eligibility for pensions or insurance for women, or to advance it, as in the case of compulsory retirement for non manual employment. For purposes of our survey of European cultures the age of 65 as marking the beginning of the later stage of aging will generally be used

In this introductory chapter answers to *four* main questions will be sought *to provide* background for the *chapters* that follow

1 What are the trends *of* social change which underlie the emergence of the problems of aging in countries *of* Western culture?

2 What have been the effects *of these* trends on aging and its *problems in these* European countries?

3 How do these countries *differ from one* another in the problems of aging?

4 What are *the chief* areas of societal concern which find expression in social action?

II Social Trends in Aging

All the countries of Western culture have experienced the economic and social *effects* of the industrial revolution *The* change from agriculture to *manufacture* as the basic mode of production set in motion a series of economic and social trends We will now review those which have special significance for an understanding of the problems of aging in modern cultures

A *The Change from Home to Factory Production*

The immediate and most visible effect *of* the industrial revolution was that the production of goods was taken out of the home and placed in the factory This meant the separation of work *from* the home Earlier the family had been the unit of production as on the farm or in the shop in town

Another aspect of this *change was the* great decrease in owners and entrepreneurs

TABLE 1

[illegible]

Country	Early Year	Per Cent	Later Year	Per Cent
France	1936	29 1	1954	28 6
Italy	1936	42 6	1951	37 2
Sweden	1940	28 5	1950	22 2
United Kingdom	1931	13 2	1951	10 5
West Germany	1936	28 0	1950	23 0

The shift was from employer to *employee* Instead of operating his own business the average person worked under the direction of his employer

The proportion of self-employed to all occupied persons not only *is small* in countries *of* Western culture but is decreasing *as Table 1* shows Italy and France have the highest proportion *of self* employed because of the large number engaged in agriculture and small business *in these* countries The United Kingdom has the lowest proportion of *persons* working for themselves, which corresponds with its position as a highly industrialized country with a minimum of *agriculture* Even in a [illegible]

39 8 in 1951 The presumption is that this

of Western culture It was decided instead to concentrate upon six European nations which met the criteria outlined above and at the same time were representative of the remaining countries of Western culture Those selected were France, Italy, the Netherlands, Sweden, the United Kingdom, and West Germany Three other countries are considered in one or more of the chapters which follow Belgium, Denmark, and Switzerland These countries, together with Finland and Norway, were considered for inclusion in the survey It was decided to select Sweden as representative of Scandinavian countries, thereby excluding Denmark, Finland, and Norway for systematic treatment Similarly, the Netherlands was chosen over Belgium and Switzerland for inclusion from the smaller countries

All these countries meet the criteria of membership in Western culture They have all participated in a common economic, cultural, social, and political development They have all been affected, some to a greater degree than others, by the industrial revolution They enjoy in large measure a common cultural and religious heritage They have taken part in the development of political democracy, with occasional lapses into authoritarian rule in the cases of France, Italy, and Germany

Four other countries of Western culture deserve attention at this point They are Australia, Canada, New Zealand and the United States These are all non European countries but peopled by Europeans They are pioneer areas in the sense that they all passed from colonial to independent status and that the transition from agriculture to industrialization took place later than in Europe At present, however, they all fully measure up to the criteria of membership in Western culture Therefore, references where pertinent will be made to these countries

Excluded for purposes of this survey are Communist dominated countries They do not meet our criteria for membership in Western culture The Soviet Union, its satellites, and Yugoslavia differ widely in their economic and political values and institutions from those of the countries selected for inclusion All these countries have programs of old age pensions which follow, in general, the same pattern Statistical data on aging are often lacking for systematic comparisons, and there is little or no research in progress in the field of social gerontology There is, therefore, little to be learned from their experience which would be of value to workers in gerontology in the United States and other Western countries

Also omitted for systematic treatment are the many comparisons that might be made to the economically underdeveloped countries like those of Latin America, Africa, and Asia

C The Criterion of Aging

"Aging," as the term implies, is a process It begins even before birth and continues until death As such, aging is synonymous with human development Customarily, however, the term "aging" is taken to mean the later stage or stages of the process For purposes of this survey it is necessary to define aging, or, more precisely the later stage of aging, arbitrarily at a fixed age But what should this arbitrary age be?

One criterion of the lower limit of old age would be legal At what age under the law is a man or a woman eligible for an old age pension or for insurance benefits administered by the government? In eighteen European countries outside those that are Communist dominated, the pensionable ages for old age programs for men are three at 60, twelve at 65, one at 67, and two at 70 For women the corresponding pensionable ages are one at 55, eight at 60, one at 63, five at 65, two at 67, and two at 70 These figures indicate 65 as the most frequent age and give support for its selection as the arbitrary age at which aging may be said to begin

The age 65 gets unexpected support ac

nantly urban as Table 5 shows. It is interesting that the New World countries of like industrial development also have correspondingly high proportions of urban population (Table 6)

The countries of Asia and Latin America with the exception of Argentina, are predominantly rural, as seen by the data in Table 7 Communist countries also have a small proportion of urban population (Table 8)

The urban way of life develops only in part because of population density It arises even more with the division of labor,

TABLE 5*

PERCENTAGE OF URBAN POPULATION IN SELECTED WESTERN EUROPEAN COUNTRIES

Country	Year	Per Cent Urban
United Kingdom	1951	81
West Germany	1946	69
Netherlands	1947	55
France	1954	56
Sweden	1950	50
Italy	1936	45

* Source United Nations, *Demographic Yearbook 1957* Table 7

TABLE 6*

PERCENTAGE OF URBAN POPULATION IN NEW WORLD INDUSTRIAL COUNTRIES

Country	Year	Per Cent Urban
Australia	1947	69
United States	1950	64
Canada	1951	62
New Zealand	1951	60

* Source United Nations *Demographic Yearbook 1957*

with the d ffe [illegible]

[illegible] goals and roles The contrasting natures of the rural and urban ways of life are expressed in the shift from personal to impersonal social contacts and relationships, the change in social control of the conduct of the person from the primary to the secondary group, the decrease in sentimental and the increase in rational attitudes, and the decline in concrete and

TABLE 7*

PERCENTAGE OF URBAN POPULATION IN SELECTED UNDERDEVELOPED COUNTRIES

Country	Year	Per Cent Urban
Argentina	1947	62 5
Brazil	1950	36 2
Egypt	1947	30 1
India	1951	17 3
Japan	1945	27 8
Mexico	1950	42 6

* Source United Nations, *Demographic Yearbook 1957*

TABLE 8*

PERCENTAGE OF URBAN POPULATION IN SIX COMMUNIST COUNTRIES

Country	Year	Per Cent Urban
Bulgaria	1946	24 6
Czechoslovakia	1947	48 8
Hungary	1949	34 5
Yugoslavia	1948	16 2
Poland	1946	31 4
Rumania	1948	23 4

* Source United Nations *Demographic Yearbook 1957*

the growth of abstract reactions to experience The urban way of life increases the movement of population All types of mobility are stepped up residential, social or vertical, and ideational There is the growth of the mass media of communication newspapers, magazines, motion pictures, radio, and television Comparative data are available which show the differences among countries in the numbers of the audience or public for the various media of mass communication

The circulation of daily newspapers and

trend will continue for all countries of Western culture.

Women as well as men left the home to work in the factory. At present the percentage of women and of married women gainfully employed in countries of Western culture is large (Table 2). As they reach working age, children of wage-earning parents enter industry. The members of the family who are gainfully employed are more likely to work for different concerns rather than for the same company or organization.

At any rate, it is clear that the industrial revolution has largely destroyed the family as a unit of economic production. The last remaining stronghold of this type of family is on the farm and in the few other kinds of family businesses.

TABLE 2

PERCENTAGE OF FEMALES ECONOMICALLY ACTIVE IN SIX WESTERN EUROPEAN COUNTRIES

Country	Year	Ages 15–19	Ages 20–64
France.	1954	43 3	44 0
Italy ...	1955	38 2	26 8
Netherlands	1947	48 7	25 4
Sweden	1950	54 3	31 6
United Kingdom .	1951	78 2	36 0
West Germany	1950	77 5	40 1

B. From the Rural to the Urban Way of Life

The shift from rural to urban living naturally accompanied industrialization. The countries of Western culture are with few exceptions highly industrialized. This is evident by the small proportion of agricultural production to the total commodity output of a country, as shown in Table 3.

Of these countries, the United Kingdom and West Germany are the most highly industrialized; Sweden and the Netherlands are less industrialized; and France and Italy are semi-agricultural. None of these countries would be classified as mainly agricultural. Certain European countries, by contrast, are still predominantly agricultural, as shown by the nations for which data are available (Table 4).

In eleven European countries data are available for a year or more of the period 1936–38. For nine of these the percentage of agriculture to total commodity output has declined since then. For the others it has remained stationary. The trend is still continuing toward a contraction of agriculture in the national economy of Western culture and to the further growth of urban population and the urban way of life.

TABLE 3

PERCENTAGE OF AGRICULTURE TO TOTAL COMMODITY OUTPUT IN SIX WESTERN EUROPEAN COUNTRIES

Country	Year	Per Cent
France	1950	31 0
Italy	1950	43 5
Netherlands	1950	24 6
Sweden	1950	21 0
United Kingdom	1949	11 2
West Germany	1950	14 6

TABLE 4

PERCENTAGE OF AGRICULTURE TO TOTAL COMMODITY OUTPUT IN FOUR COUNTRIES

Country	Year	Per Cent
Ireland	1950	55 5
Greece	1949	61 4
Spain	1951	59 1
Turkey	1950	75 5

Urbanization, as well as industrialization, is an outstanding characteristic of Western cultures. The comparison with the predominance of rural settlement in economically underdeveloped countries is striking.

The shift from rural to urban living naturally accompanied industrialization. The countries of Western culture are predomi-

countries is in the Netherlands Sweden and France (Table 13)

The four non European countries of Western culture all have relatively high motion picture theater attendance as shown in Table 14

Underdeveloped countries are much lower in per capita attendance at motion picture theaters (Table 15)

TABLE 13*

PER CAPITA ATTENDANCE AT MOTION PICTURE THEATERS IN SIX WESTERN EUROPEAN COUNTRIES 1954 58

Country	Year	Per Capita Attendance
France	1955	9 7
Italy	1954	16 8
Netherlands	1955	6 3
Sweden	1958	9 4
United Kingdom	1955	23 2
West Germany	1955	15 3

* Source United Nations *Statistical Yearbook 1956*, Table 183B *1957* Table 187B and *1958* Table 18 B

TABLE 14*

PER CAPITA ATTENDANCE AT MOTION PICTURE THEATERS IN FOUR NON EUROPEAN COUNTRIES 1954 57

Country	Year	Per Capita Attendance
Australia	1955	15 0
Canada	1954	15 6
New Zealand	1957	18 9
United States	1955	14 5†

* Source United Nations *Statistical Yearbook 1956*, Table 183B *1957* Table 187B and *1958* Table 183B

† Estimated

Communist countries, except for Rumania and Yugoslavia compare quite favorably in attendance at motion picture theaters with the nations of Western culture as shown in Table 16

The relative distribution of radio receivers in use follows the pattern observed in the other media of mass communication Countries of Western culture are highest in use of radio receivers, underdeveloped countries are lowest, and the

TABLE 15*

PER CAPITA ATTENDANCE AT MOTION PICTURE THEATERS IN FIVE UNDERDEVELOPED COUNTRIES 1953-57

Country	Year	Per Capita Attendance
Argentina	1957	3 9
Brazil	1955	5 3
Egypt	1955	2 8
India	1953	2 0†
Mexico	1957	8 5

* Source United Nations *Statistical Yearbook 1956*, Table 183B *1957* Table 187B and *1958* Table 183B

† Estimated

TABLE 16*

PER CAPITA ATTENDANCE AT MOTION PICTURE THEATERS IN EIGHT COMMUNIST COUNTRIES 1955

Country	Per Capita Attendance
Bulgaria	7 3
Czechoslovakia	12 4
East Germany	17 2
Hungary	11 8
Poland	8 1
Rumania	4 0
Yugoslavia	5 7
U S S R.	12 6

* Source United Nations, *Statistical Yearbook 1956*, Table 183B *1957* Table 187B and *1958* Table 183B

majority of Communist countries are in between In Europe, Sweden has a con [illegible]

[illegible] non European countries of Western culture—Canada and the United States—have rates of radio receivers in use far in excess of that of Sweden, which has the highest rate in Europe, as can be seen in Table 18

newsprint consumption are closely related to the degree of industrialization and urbanization. The United Kingdom and Sweden are the highest, and Italy the lowest, in newspaper circulation and per capita newsprint consumption (Table 9).

TABLE 9*

NEWSPAPER CIRCULATION AND PER CAPITA NEWSPRINT CONSUMPTION IN SIX WESTERN EUROPEAN COUNTRIES

Country	Year	Daily Newspaper Circulation per 1000 Population	Newsprint Consumption Per Capita
France	1956	244	10 2
Italy	1956	107	3 6
Netherlands	1956	264	11 1
Sweden	1956	462	23 3
United Kingdom	1954	573	19 0†
West Germany	1956	277	7 2‡

* Source United Nations, *Statistical Yearbook 1957*, Tables 184-85, *1958*, Tables 180-81

† 1956

‡ West Germany and West Berlin

TABLE 10*

NEWSPAPER CIRCULATION AND PER CAPITA NEWSPRINT CONSUMPTION IN FOUR NON-EUROPEAN COUNTRIES

Country	Year	Daily Newspaper Circulation per 1000 Population	Newsprint Consumption Per Capita
Canada	1956	244	26 0
Australia	1957	381	28 2
New Zealand	1956	390	28 7
United States	1956	337	38 0

* Source United Nations, *Statistical Yearbook, 1957*, Tables 184-85, *1958*, Tables 180-81

The non-European countries of Western culture are all relatively high in daily newspaper circulation and per capita newsprint consumption. They are all lower than the United Kingdom in daily newspaper circulation per 1000 population, but their newspapers are larger, as shown by the newsprint consumption, than in the European countries (Table 10).

The underdeveloped countries have low daily newspaper circulation and small use of newsprint per capita, as shown by Table 11.

TABLE 11*

NEWSPAPER CIRCULATION AND PER CAPITA NEWSPRINT CONSUMPTION IN FIVE UNDERDEVELOPED COUNTRIES

Country	Year	Daily Newspaper Circulation per 1000 Population	Newsprint Consumption Per Capita
Argentina	1956	159	5 8
Brazil	1955	50	2 9
Egypt	1952	25	1 1
India	1953	7	0 2
Mexico	1952	48	2 8

* Source United Nations *Statistical Yearbook 1957*, Tables 184 85 *1958* Tables 180-81

TABLE 12*

NEWSPAPER CIRCULATION AND PER CAPITA NEWSPRINT CONSUMPTION IN EIGHT COMMUNIST COUNTRIES

Country	Year	Daily Newspaper Circulation per 1000 Population	Newsprint Consumption Per Capita
Bulgaria	1956	170	2 0
Czechoslovakia	1956	170	
East Germany	1954	118†	
Hungary	1956	122†	
Poland	1956	150	1 8
Rumania	1957	149	1 8‡
Yugoslavia	1956	48	1 2
U S S R	1956	107	1 6

* Source United Nations *Statistical Yearbook 1957* Tables 184 85 *1958*, Tables 180-81

† Estimated

‡ 1956

In Communist countries daily newspaper circulation and newsprint consumption are, in general, intermediate between those of countries of Western culture and underdeveloped countries (Table 12)

The United Kingdom has the highest annual per capita motion-picture theater attendance—*23.2*—in the world The lowest per capita attendance of our six European

tion of the role of the husband prevailed When the extended family in the city fell apart into its component units, the conjugal family emerged It was a small group of husband wife and children It was no longer a work group with the husband taking the roles of employer, rule issuer, and decision maker

At first the husband and father maintained his authoritarian position in the conjugal family in the city He was superordinate and the wife subordinate Decision making remained in his hands Children were expected to respect and obey their parents Discipline was rigid and severe Gradually however, the roles of husband and wife changed from inequality to *equality*, and a companionship relation developed Sociologists describe this transition as from the institutional or traditional *family to* the companionship or modern family

By the family as an institution is meant that its members are held together by the external social controls of public opinion, the mores and law The members of the companionship form of the family are united by the internal bonds of love congeniality and common objectives Other characteristics of the institutional family are authority of the husband and father, inferior status of the wife strict discipline of the children and emphasis upon duty The contrasting features of the companionship family are shared authority by husband and wife equality in the status of each respect for the individuality of the child and emphasis upon the personality development of members of *the family*

A number of factors combined to accelerate the emergence of the companionship family Among these was the emancipation of woman in the economic educational social and political areas of her life The separation of home and work increased the responsibility and authority of the wife in the family The greatest single factor in raising her status in the family followed her gainful employment outside the home This economic independence tended to give her co-ordinate authority with the husband in decision making in the home

The effect of two world wars was, also to raise the status of women They entered into jobs from which they had previously been barred As wives they took over household responsibilities that had until then been reserved to their husbands

The development of the companionship family has proceeded furthest in the United States (*Burgess and Locke, 1953*) It has, however, emerged in all countries of western Europe It is further advanced in the more highly industrialized and urban countries than in others In all Western countries it tends to develop in the upper middle class and to be less evident in the wage earning classes

Survivals of the extended family persist in all countries of Western culture. In Italy and France, with their large rural populations, its ties are still strong In other countries the older and the younger generations maintain communication and contacts, engage in reciprocal services, and participate in reunions and family events and celebrations

D The Rise of Large Organizations

The trend throughout Western culture, but at a more rapid rate in some countries than others, has been toward the rise of large organizations This trend is not confined to the economic sphere of life, although it is perhaps more marked here than in the social, recreational, educational and political areas

In the United States the development of organization has been so pronounced that an economist, Kenneth Boulding (1953), has written a book on the organizational revolution Our interest here is not in the facts of organization per se but in their effects upon people in the organization

There is, first of all, the technological organization of the factory to facilitate mass production The assembly line sets a pace for all the workers to follow Then there is the organization of employees at

Underdeveloped countries have a very low proportion of radio receivers in use per 1000 population, as shown in Table 19.

Communist countries, except for Czechoslovakia and East Germany, have a relatively low rate of radio receivers per 1000 population (Table 20).

TABLE 17*

RADIO RECEIVERS IN USE IN SIX WESTERN EUROPEAN COUNTRIES, 1956

Country	No (In Thousands)	Per 1000 Population
France	10,158	233
Italy	6,306	131
Netherlands	2,878	264
Sweden	2,548	348
United Kingdom	14,434	281
West Germany	14,051	277

* Source United Nations *Statistical Yearbook, 1957* Table 189, *Estimates of Population 1956*, Table 1

TABLE 18*

RADIO RECEIVERS IN USE IN FOUR NON-EUROPEAN COUNTRIES, 1955-56

Country	Year	No (In Thousands)	Per 1000 Population
Australia	1955	2,051	223
Canada	1956	9,050	563
New Zealand	1956	519	238
United States	1956	150,000	892

* Source United Nations, *Statistical Yearbook, 1957* Table 189, *Estimates of Population, 1956*, Table 1

C. Breakup of the Extended Family and Emergence of the Conjugal Family

The decline of the extended family has proceeded—at varying rates, to be sure—in all countries of Western culture. It gave up its natural habitat when its members migrated from the country to the city. Conditions of urban living were unfavorable to its survival.

René König (1956) points out that recent research in Yugoslavia by Bicanic and in Finland by Pipping indicates that the disintegration of the extended family began in the pre-industrial period when changes in agriculture made the large family a burden instead of an asset. In Yugoslavia the precipitation of the breakdown of the extended family as a working unit was the transition from farming with two or three pair of oxen and four or five men to plowing by one man with two horses and an iron plow.

TABLE 19*

RADIO RECEIVERS IN USE IN FOUR UNDERDEVELOPED COUNTRIES, 1954-56

Country	Year	No (In Thousands)	Per 1000 Population
Brazil	1954	3500	61
Egypt	1956	850	36
India	1956	1076	3
Mexico	1955	2500	84

* Source United Nations, *Statistical Yearbook, 1957*, Table 189, *Estimates of Population, 1956*, Table 1

TABLE 20*

RADIO RECEIVERS IN USE IN SEVEN COMMUNIST COUNTRIES, 1954-56

Country	Year	No (In Thousands)	Per 1000 Population
Bulgaria	1954	350	47
Czechoslovakia	1956	2,906	220
East Germany	1955	5,000†	299
Hungary	1956	1,587	161
Poland	1956	3,624	130
Rumania	1955	1,164	67
U S S R	1956	29,571	148

* Source United Nations, *Statistical Yearbook, 1957*, Table 189 *Estimates of Population 1956* Table 1

† Estimated

The separation of the home from work and the move of the family from the rural village to the urban community undermined the economic bases of the extended family. Under these conditions the traditional type of husband-wife relations also changed. During the dominance of the extended family the authoritarian concep-

culture and economically underdeveloped countries (Table 24)

The greatest success in the conservation of human life has been in the tremendous reduction in infant and maternal mortality All countries of Western cultures have scored brilliant successes in achieving low rates of infant mortality (Tables 25 and 26) Rates are the number of deaths of infants under 1 year per 1000 live births Similar low rates of infant and maternal mortality are reported for the non European countries of Western culture By contrast the corresponding rates for the economically underdeveloped countries are

TABLE 21*

AVERAGE LIFE EXPECTANCY AT BIRTH SIX WESTERN EUROPEAN COUNTRIES

Country	Year	Males	Females
France	1950–51	63 8	69 3
Italy	1950–55	63 6	67 3
Netherlands	1950–52	70 6	72 9
Sweden	1946–50	69 0	71 6
United Kingdom England and Wales	1950	66 5	71 2
West Germany	1949 51	64 6	68 5

*Source United Nations *Demographic Yearbook 1957* Table 24

TABLE 22*

AVERAGE LIFE EXPECTANCY AT BIRTH FOUR NON EUROPEAN COUNTRIES

Country	Year	Males	Females
Australia	1946–48	66 1	70 6
Canada	1950–52	66 3	70 8
New Zealand	1950–52	68 3	72 4
United States†	1949–51	65 5	71 0

*Source United Nations, *Demographic Yearbook 1957* Table 24

†The rate for the United States for the white population for 19 0 are male, 66 6 female 72 4

high as shown in Table 27 The infant mortality rates of Communist countries, with the exception of Czechoslovakia, are closer to underdeveloped countries than they are to Western nations (Table 28)

Six trends have been chosen to give background to our consideration of aging and its problems in modern Western societies The first five of these are obviously interdependent they are the change from home to factory production, the transition from the rural to the urban way of life, the

TABLE 23*

AVERAGE LIFE EXPECTANCY AT BIRTH, THREE UNDERDEVELOPED COUNTRIES

Country	Year	Males	Females
Brazil (Federal District)	1949–51	49 8	56 0
India	1941–50	32 5	31 7
Mexico	1940	37 9	39 8

*Source United Nations *Demographic Yearbook 1957* Table 24

TABLE 24*

AVERAGE LIFE EXPECTANCY AT BIRTH THREE COMMUNIST COUNTRIES

Country	Year	Males	Females
Hungary	1948–49	58 8	63 3
Poland	1948	55 6	6? 5
U S S R.	1955 56	63 0	69 0

*Source United Nations *Demographic Yearbook 1957* Table 24

breakup of the extended family and the emergence of the conjugal family, the rise of large organizations, and the growth of automation and the increase in leisure time The sixth trend is the conservation of human life

All these trends have effected great transformations in our style of life, in our thinking and in our behavior Only one of them was intended, namely, the conservation of life The others were developments that are still continuing to shape our changing society and the personality of its members

The net effect of these dynamic trends has had on the whole, an adverse impact upon the aging segment of countries of Western culture These effects will now be taken up in some detail

different levels of operation and responsibility. There arise the problems of co-operation, conformity, and personal integrity that confront the organization man, as pointed out by Whyte (1956).

The picture is essentially the same in nearly all the other areas of human life in modern society. The individual often feels submerged in the large organizations in which his life is enmeshed. The average person seems to count for little or nothing in the large organization. A church member feels lost in a congregation of one thousand souls. A voter feels the futility of his one ballot when over sixty million vote in a presidential election.

More serious than apathy is the conflict which arises within the person from his impulse to conform to the pressure exerted by the organization and his wish to express his own views and hold out for their adoption. The basic problem is to find means of stimulating individual initiative, self-expression, and originality and at the same time to promote the values inherent in the team play and efficiency that derive from organization.

At any rate, human beings are increasingly dependent upon organizations for opportunity for the realization of their desires. Until recently, retired people have been largely without participation in organizations and without a share in the benefits of membership in them.

E. Automation and the Increase of Leisure Time

The transition from handwork to mass production of commodities has made possible both a rise in the standard of living and a reduction in the hours of work.

Automation in all countries of Western culture, and particularly in the United States, where it has developed most rapidly, poses a threat and a promise. The threat is the displacement of workers from their jobs. This danger is greatest for the older worker who finds it difficult, if not impossible, to get re-employment. The promise of automation is a reduction of work, a rise in the standard of living, and an increase of leisure time. No country of Western culture has worked out adequate protection against the readjustment of the employees displaced by automation.

One manifestation of the increase in leisure time is the introduction of compulsory retirement at a fixed age. Optional retirement at earlier ages appears to be a partial solution of the problem of automation. We are toward the end of an era predominantly motivated by the philosophy of work. We are to enter a new age where enjoyment of leisure will increasingly take over the center of the stage.

No country of the Western world has as yet seriously faced the challenge of the changes now in progress. Evidence of public response to the new boon of more leisure is found in the increasing popularity of travel, in the enjoyment of vacations, and in the new meaning of the week end.

The trend to automation and the increase of leisure time call for new social inventions and new forms of organization to maximize their advantages and minimize their disadvantages.

F. The Conservation of Human Life

All Western cultures are concerned with the conservation of human life. They have all achieved, as compared with economically underdeveloped countries, a marked increase in life expectancy. For our six selected European countries the average number of years of life which males and females can expect at birth is presented in Table 21. The Netherlands has the highest life expectancy at birth of any country in the world. Four non-European countries of Western culture also have high rates of life expectancy, as shown in Table 22.

All these rates are very much higher than for economically underdeveloped countries, as Table 23 reveals.

The life expectancy at birth of Communist-dominated countries is intermediate between those of nations of Western

culture and economically underdeveloped countries (Table 24)

The greatest success in the conservation of human life has been in the tremendous reduction in infant and maternal mortality All countries of Western cultures have scored brilliant successes in achieving low rates of infant mortality (Tables 25 and 26) Rates are the number of deaths of infants under 1 year per 1000 live births Similar low rates of infant and maternal mortality are reported for the non European countries of Western culture By contrast the corresponding rates for the economically underdeveloped countries are high as shown in Table 27 The infant mortality rates of Communist countries with the exception of Czechoslovakia are closer to underdeveloped countries than they are to Western nations (Table 28)

TABLE 21*

AVERAGE LIFE EXPECTANCY AT BIRTH SIX WESTERN EUROPEAN COUNTRIES

Country	Year	Males	Females
France	19[illegible]0–31	63 8	69 3
Italy	19[illegible]0–5[illegible]	63 6	6[illegible] 3
Netherlands	19[illegible]0–52	[illegible]0 6	[illegible]2 9
Sweden	1946–50	69 0	[illegible]1 6
United Kingdom, England and Wales	19[illegible]0	66 5	[illegible]1 2
West Germany	1949–51	64 6	68 [illegible]

*Source United Nations Demographic Yearbook 1957 Table 24.

TABLE 22*

AVERAGE LIFE EXPECTANCY AT BIRTH FOUR NON EUROPEAN COUNTRIES

Country	Year	Males	Females
Australia	1946–48	66 1	[illegible]0 6
Canada	1950–52	66 3	70 8
New Zealand	19[illegible]0–52	68 3	72 4
United States†	1949–51	6[illegible] 5	71 0

*Source United Nations, *Demographic Yearbook 19[illegible]* Table 24

† The rate for the United States for the white population for [illegible]-0 are male, 66.6 female, 72.4.

Six trends have been chosen to give background to our consideration of aging and its problems in modern Western societies The first five of these are obviously interdependent they are the change from home to factory production the transition from the rural to the urban way of life, the breakup of the extended family and the emergence of the conjugal family, the rise of large organizations, and the growth of automation and the increase in leisure time. The sixth trend is the conservation of human life

TABLE 23*

AVERAGE LIFE EXPECTANCY AT BIRTH THREE UNDERDEVELOPED COUNTRIES

Country	Year	Males	Females
Brazil (Federal District)	1949–51	49 8	56 0
India	1941 50	32 5	31 [illegible]
Mexico	1940	[illegible] 9	39 8

*Source United Nations, *Demographic Yearbook 19[illegible]* Table [illegible].

TABLE 24*

AVERAGE LIFE EXPECTANCY AT BIRTH THREE COMMUNIST COUNTRIES

Country	Year	Males	Females
Hungary	1948–49	59 8	63 3
Poland	1948	5[illegible] 6	6[illegible] 3
U.S.S.R.	1955–56	63 0	69 0

*Source United Nations, Demographic Yearbook 19[illegible] Table 2[illegible]

All these trends have effected great transformations in our style of life in our thinking and in our behavior Only one of them was intended, namely, the conservation of life. The others were developments that are still continuing to shape our changing society and the personality of its members

The net effect of these dynamic trends has had, on the whole an adverse impact upon the aging segment of countries of Western culture These effects will now be taken up in some detail.

III. Effects upon Aging

The total effect of these trends upon older people constitutes a paradox The proportion of older people in the total population of countries of Western culture has increased tremendously, but their function, role, and status have declined.

TABLE 25

Infant Mortality Rate, Six Western European Countries, 1955

Country	Rate
France	38 6
Italy	50 9
Netherlands	20 1
Sweden	17 4
United Kingdom	25 9
West Germany	41 7

TABLE 26

Infant Mortality Rate, Four Non European Industrial Countries, 1955

Country	Rate
Australia	22 0
Canada	31 3
New Zealand	24 5
United States	26 4

A Prolongation of Life

More people are living beyond 65 years of age than a century ago Exact figures are not available for all countries of Western culture, largely because of changes of political boundaries and the lack of statistical data for the earlier period. But the increase in the proportion of older persons is impressive, as can be seen from Table 29

In one hundred years the percentage of population 65 years of age and over more than doubled in Great Britain and Sweden and almost doubled in France and the Netherlands For the United States the estimated increase was even greater. The proportion quadrupled Comparable data are not available for Italy and West Germany. The largest factors in the increasing proportion of people living beyond 65 has been (*a*) the great decrease in infant and child mortality, (*b*) the reduction in the death rate from communicable and other diseases of early and middle adulthood, and (*c*) the decreasing proportion of population under age 20 resulting from a declining birth rate

In countries of Western culture people who pass the 65-year mark are living longer but not much longer than 50 or 100 years ago. At the age of 65 the expected years of life remaining for men and women are given for our six selected countries in Table 30.

Of these six countries, at age 65 the expected number of years remaining is highest for men (14 1) and for women (15 0) in the Netherlands It is lowest for men in the United Kingdom (11 9) and for women in Italy and West Germany (13 7 years). The range is wider for men (2 2 years) than for women (1.3 years) The highest life-expectancy at age 65 in the world has been reported for Norway (14.9 for men and 16 0 for women).

It is interesting and, I believe, significant to note that in all countries of West-

TABLE 27

Infant Mortality Rate, Six Underdeveloped Countries, 1955

Country	Rate
Argentina	62 0*
Brazil	170 0†
Egypt	148 5
India	99 9
Mexico	83 3
Venezuela	69 9

* Estimate for 1940–50
† For 1950

TABLE 28

Infant Mortality Rate, Six Communist Countries, 1955

Country	Rate
Bulgaria	82 4
Czechoslovakia	34 1
Hungary	60 0
Poland	81 4
Rumania	78 2
Yugoslavia	112 8

ern culture and in almost all others the life-expectancy at age 65 is higher for females than for males This difference might be explained as of biological origin except for a significant fact The differences between the sexes in the number of remaining years is not uniform from country to country It is large in some but very small in others The largest differences in the six countries reported on above are for the United Kingdom (3 0 years) and for France (2 5 years), or 20 per cent higher for women than for men The corresponding percentage for the United States is as high For the other countries the differences are small ranging from 10 to 13 months (1 1 years for Italy, 1 0 years for Sweden 0 9 years for the Netherlands, and 0.8 years for West Germany) Evidently, the cause is not due to innate biological differences between the sexes but is to be found in environmental and social factors. Further research might well lead to significant findings

TABLE 29*

PERCENTAGE OF POPULATION 65 YEARS AND OVER IN SIX WESTERN COUNTRIES

Country	1850	1900	1950
France	6 5	8 2	11 8
Italy		6 2	8 3
Netherlands	4 8	6 0	7 7
Sweden	4 8	8 4	10 3
United Kingdom	4 6	4 7	10 8
United States	2 5†	4 1	8 1

* Source United Nations *The Aging of Populations and Its Economic and Social Implications* 1956 and, for Italy (1958) United Nations, *Demographic Yearbook* 1956 Table 4

† Estimated

Jean Daric (1954) explains how in France the prolongation of life of older persons has differentially affected the family structure and relations in the country and in the city In France the average duration of life increased 25 years between 1850 and 1930 The result in rural districts was a marked aging of the heads of families and managers of agricultural production Since they had the disposition of the patrimony, their sons had to wait much longer to obtain full control of the farm As a consequence, the more enterprising youth migrated to the cities The older generation tended to be resistant to modern agricultural methods.

In the city the increase of life-expectancy and the decrease in number of children has rendered the situation of aged persons very precarious The burden of supporting old parents falls upon a greatly reduced number of adult children "The loosening of family solidarity and the conditions of urban life diminish the chances of being taken into the homes of their children. The city family is more and more reduced to the couple and their unmarried children This explains why the systems of social security for the aging have arisen in the city" (Daric, 1954, p 334)

TABLE 30*

YEARS OF LIFE REMAINING AT AGE 65 IN SIX WESTERN EUROPEAN COUNTRIES

Country	Year	Men	Women
France	1952 56	12 1	14 6
Italy	1950-53	12 6	13 7
Netherlands	1953 55	14 1	15 0
Sweden	1951 55	13 8	14 8
United Kingdom	1956	11 9	14 9
West Germany	1949 51	12 9	13 7

* Source United Nations, *Demographic Yearbook* 1958 Table 31

B The Paradox of Security and Insecurity

The security which the older person formerly had in the family is now supplied by the state Old age and survivor's insurance or government pensions protect him against want and against disabling illness The prolongation of life means that more people can count on living beyond 65 years and that they may live somewhat longer after they reach that age

This security in a more favorable life expectancy is countered by insecurity because of fear of the incidence of disabling

illness in the later years. The fact is that there has been a rising curve of physical and mental disabilities in the later years of life. As measured by care in hospitals, the increase has been even greater than the increase in the number of those 65 years and over.

In terms of rates of mortality there is an increase in our selected countries of Western culture in diseases of the heart and other cardiovascular conditions and cancer (Table 31). It is generally lower in pneumonia and tuberculosis. Only in Italy, of these five countries, was there a decrease in the period 1931–49 in heart and other cardiovascular conditions. The Netherlands reported a small decrease for both men and women, and the United Kingdom noted a decrease for cancer in women

From 1931 to 1949 large decreases were reported for tuberculosis in European countries of Western culture in the middle-aged group (45–64). Except for France, it decreased for the age group 65 and over in the five nations listed in Table 32. Pneumonia and influenza decreased markedly for both middle-aged and older persons in all five countries except France (Table 32).

One of the two major anxieties of retired people is the possibility of prolonged illness against which there is no complete protection except in the United Kingdom by the National Health Service or elsewhere by private health insurance. The second major insecurity is the fear of inflation which haunts older persons. Inflation is an economic malady which afflicts all countries of Western culture. The fig-

TABLE 31

DEATH RATES PER 100,000 FOR AGES 65 AND OVER

Country	Heart and Other Cardiovascular Diseases				Cancer			
	1931		1949		1931		1949	
	Male	Female	Male	Female	Male	Female	Male	Female
France	2786	2219	3793	2896	551	490	1029	760
Italy	3486	3376	3340	3205	491	437	754	605
Netherlands	2762	2980	2885	3154	1189	999	1136	977
Sweden*	3914	3756	5044	4970	1016	840	1081	895
United Kingdom	4133	3608	4399	3864	1111	886	1167	808

* For Sweden the age group is 70 and over

TABLE 32

DEATH RATES PER 100,000 FOR AGES 65 AND OVER

Country	Tuberculosis				Pneumonia and Influenza			
	1931		1949		1931		1949	
	Male	Female	Male	Female	Male	Female	Male	Female
France	126	73	150	81	507	486	549	490
Italy	72	63	55	37	1035	986	452	390
Netherlands	112	94	87	81	996	1031	458	492
Sweden*	104	105	78	57	978	1113	336	387
United Kingdom	72	63	55	37	494	474	353	296

* For Sweden the age group is 70 and over

ures given in Table 33 are percentage increases in the cost of living from 1948 to 1956 Except for West Germany, these are all considerable rises They markedly affect the purchasing power of everyone who is on a fixed income For most retired persons inflation of this magnitude unless counterbalanced by rise in pensions and insurance benefits has disastrous consequences for their standard of living

C Loss of Priority by the Family

In all societies of the past and in Western countries before the industrial revolution the extended family provided security protection and reciprocal services to its members Ogburn and Tibbitts (1933) have amassed the evidence to show the loss by the family of its historic functions of economic production care of health leisure-time activities religious practices, education and protection

The full force of these shifts has fallen heaviest on the older person He can no longer count as a matter of right and of moral and legal obligation on economic support by his children He is less and less likely if widowed to be offered a home by a son or a daughter If ill particularly with a chronic ailment his children are more and more disposed to shift his care to a hospital rather than to provide a bed in their home If lonely he must more and more look elsewhere than to his descendants to provide companionship and sociability In short he must seek elsewhere for the satisfaction of his needs—financial health and social In Western cultures he turns to the government or to other organizations

D Organizations Take Over First Place

The older person like those in all age groups in modern society must rely less upon the family and more on organizations for support and for the fulfilment of his desires Organizations in Western countries are taking the primary place which the family had held from the beginning of human history

The national government previously had seemed remote from the everyday life of the older person It now mails to him his monthly pension or insurance check He moves into housing specially designed for older residents which is subsidized by national state, or municipal governments Medical care in the home hospital or geriatric clinic is in many European countries under governmental auspices In England Sweden and other nations such medical care is available to residents from infancy through old age

In the United States with its greater reliance on private agencies other organizations than governmental play a larger

TABLE 33*

INCREASE IN COST OF LIVING SIX WESTERN EUROPEAN COUNTRIES 1948-56

Country	Per Cent
France	34
Italy	29
Netherlands	36
Sweden	42
United Kingdom	45
West Germany	13

* Source International Monetary Fund *International Financial Statistics* Vol 10 (October 1957)

role than in Europe If the individual takes the initiative in making financial provision for retirement he relies less on making his own investments but rather more upon savings banks building and loan associations investment trusts and life insurance companies In addition the company or organization for which he works often makes provision for pensions or annuities for its retired employees

Data for the different countries of Western culture are available to compare the ratio of life insurance in force to national income (Table 34) Insurance in force figures for the United Kingdom and West Germany used in calculating the ratios represent insurance in force in domestic companies of the country including their foreign business. For other countries insurance in force used is on lives of residents

of the country in both domestic and foreign countries These ratios indicate that the people of less industrialized countries, such as France and Italy, rely less on life in surance than do persons in other countries For non European countries of Western culture the ratio of life insurance in force to national income is much higher and in creasing more rapidly than for the above countries (Table 35)

TABLE 34*

PERCENTAGE OF LIFE INSURANCE IN FORCE TO NATIONAL INCOME SIX WESTERN EUROPEAN COUNTRIES

Country	1950	1957
France	10	16
Italy	8	13
Netherlands	51	49
Sweden	43	52
United Kingdom	56	57
West Germany	20	28

* Source Institute of Life Insurance and Statistical Office of the United Nations

Health insurance in the United States more than in Europe is also a matter for private rather than for governmental or ganizations The Blue Cross and the Blue Shield are the best known of many similar organizations offering payment of the med ical bills of hospitals and physicians Pio neering demonstrations in group medical care are in progress under the auspices of companies and other organizations

The dependence of the older person upon organizations is not limited to economic support, to housing, and to provision for health care It extends over the entire range of his interests and activities He needs, especially, organizations through which he can realize the potentialities of utilizing the leisure conferred upon him by retire ment Certain existing organizations like the church and the schools are beginning to reorient their programs to meet the needs of older people These institutions have an opportunity to provide for certain of the leisure time interests of older people

E Leisure and Loneliness

The superabundance of leisure of older people results naturally from retirement But many of them are not prepared for a life of leisure They have lived in the work oriented countries of Western culture Work has been central in the lives of men Housework has had a similar significant meaning for women

Since 1900 the hours of work have been reduced from the 12 hour day to 8 hours for 6 days or 5½ days a week Automation promises further shortening of the work week in terms of days worked or hours per day

Relatively few workers when they retire are prepared to use this sudden gift of free time That is one of the reasons that at 65 when eligible for retirement benefits so many of them, especially men, desire to continue in their jobs or to find new em ployment

But only a minority of men and women 65 years and over are gainfully employed (United Nations, 1957–58) France and Sweden are tied for first place in the per centage of men economically active (36 1) with the Netherlands a close third (35 5) Fourth fifth and sixth places are taken by Italy (33 0), the United Kingdom (32 0), and West Germany (26 8)

TABLE 35*

PERCENTAGE OF LIFE INSURANCE IN FORCE TO NATIONAL INCOME FOUR NON EUROPEAN INDUSTRIAL COUNTRIES

Country	1950	1957
Australia	42	62
Canada	115	146
New Zealand	63	88
United States	97	126

* Source Institute of Life Insurance and Statistical Office of the United Nations

A much smaller proportion of women are economically active France has the high est percentage (13 5), the United King dom the lowest (5 3) Second to fifth

places are held by West Germany (9 7), Italy (8 6), Sweden (7 8), and the Netherlands (6.3)

The differences between these countries are not large and are due to a complex of factors Among the reasons for low percentages are the degree of industrialization the effect of eligibility for social insurance benefits, and extent of unemployment. Among the factors making for high percentages are the extent of self-employment the prevalence of agriculture and the proportion of small businesses

The main point, however, is that in western Europe as well as in the United States the gainful employment of older men is on the decline Although this country had in 1950, 41 4 per cent of men 65 years of age and older economically active —higher than any of the six European countries—estimates are for a continuing decline

The opportunity for remunerative work by older men and women has been decreasing in all countries of Western culture and in all probability will keep on becoming smaller The problem then becomes how to give retired persons substitute leisure-time activities from which they will get the satisfactions other than income which they obtained from work.

Havighurst and his associates in their studies of the meaning of work and retirement indicate that other satisfactions are often as important as or even more important to the worker than income (Friedmann and Havighurst 1954) Among these are having friends on the job, keeping busy, feeling useful getting status having self respect being creative and being of service

Research findings show that those who have been most absorbed in their work with few if any outside interests are those who have the greatest difficulty in adjustment to retirement They are at a loss to know how to fill their leisure time with satisfying activities Not being able or even interested in making new friends, they may become lonely and unhappy The opportunity for leisure does not automatically provide activities and guarantee happiness

The increase of leisure, instead of diminishing loneliness, may, therefore, actually augment it Retirement from work generally means the loss of friends on the job These may be the only or almost the only friends of the man or woman whose life is centered in work Work was also a way of scheduling time Withdrawal from the job leaves a void which some workers are not able to fill The person with nothing to do becomes lonely

Other factors enter into the increase of loneliness in modern society The most important one, perhaps, follows from the breakup of the extended family In the past the large group of relatives living in proximity provided a common social life for its members The conjugal family of husband and wife and children at best assures the older person of only a minimum of social life

The high mobility of modern society leads to the dispersal not only of relatives but of friends The friends of childhood and of [illegible] likely [illegible] find [illegible] found in Bethnal Green a district in East London, that 5 per cent of the old people he interviewed said that they were "very lonely," 22 per cent "sometimes lonely," and 72 per cent "not lonely" The Milan, Italy, study of older people (1291 men and 2276 women 55 and over) reports replies of "very lonely" by 10 per cent of the men and 13 per cent of the women and of "sometimes lonely" by 20 per cent of the former and 22 per cent of the latter The statements of loneliness increase with age at ages 60–64, "very lonely," 8 per cent of men, 13 per cent of women, at age 85 and older, 18 per cent of both sexes, at ages 60–64, "occasionally lonely," 17 per cent of men, 20 per cent of women, at age 85 and older, 24 per cent of men, 21 per cent of women (Ingegnieros, 1958) In a representative sample of 890 older persons in

California the proportion of "very lonely" varied from 57 per cent of those married but not with spouse to 16 per cent of those living with spouse only (Bond, 1954)

F Roleless Role of the Aging

Modern economic social trends have brought losses as well as gains to all age groups in the population But the full impact of their adverse effects has been experienced by the aging Let us recapitulate the series of blows which struck them one after another First, they lost their economic independence They were demoted from the status of employer to that of employee Their place of work was no longer the home but the factory or office Second, in increasing numbers they had to give up rural residence for urban living Third, they were now forced to retire from work by the decision of the employer rather than of their own free will as in the past Fourth, they lost their former favored position in the extended family No longer were the grandfather and the grandmother the center of the absorbing social life of their descendants but often became unwanted hangers on, taking part by sufferance in the activities of their children and grandchildren Fifth, deprived of the society of their family and having lost associates on the job and other friends by death or departure to other communities, they found themselves cursed instead of blessed by leisure time in abundance and little or nothing to do with it

In short, the retired older man and his wife are imprisoned in a roleless role They have no vital function to perform such as they had in rural society This is doubly true of the husband, because a woman as long as she is physically able retains the role and satisfactions of homemaker Nor are they offered a ceremonial role by society to make up in part for their lost functional role

This roleless role is thrust by society upon the older person at retirement, and to a greater or lesser degree he has accepted it or become resigned to it The retired person speaks of being "turned out to pasture," "put upon the shelf," or given "a rocking chair on the porch to watch the world go by" Certain stereotypes and myths have grown up in Western cultures to sanction this roleless role They may be briefly stated as follows

1 *Passive behavior* is the expected pattern for the older person in retirement. He should now "take it easy, loaf, and fish" He has worked so hard all his life that now he wants only to rest

2 *Dependence* on others for advice and assistance is the natural and inevitable consequence of advancing years Ethel Shanas (unpublished paper) has analyzed this as a reversion in second childhood to the baby role

3 *Custodial care* in institutions is the answer to chronic illness, invalidity, and the mental disturbances common in old age Accordingly, the proportion of older persons with physical and mental illnesses occupying hospital beds has increased faster than their percentage of the population

4 *Withdrawal from social participation* tends to accompany departure from employment Often the older person feels "elbowed out" of groups by subtle pressures

5 *No preparation* for retirement is required or expected Older persons, it is asserted, need only to relax, read and listen to radio and television

6 *Circulation of myths* which have no basis in fact is prejudicial to older persons Typical of these are that older workers are unable to learn new skills and have more accidents, more absences, and less productivity than younger workers

These stereotypes are prevalent in the public mind and are often accepted by older workers They are the greatest obstacle to progress by society and by the older person himself Milton L Barron (1953) has characterized our older citizens as a minority group inasmuch as they suffer from discrimination in the same way

as do racial and ethnic groups In this sense they are second-class citizens and are deprived of their full rights to economic social and civic participation

This analysis of the roleless role of the older person is what the sociologist calls an "ideal construction It is a conscious distortion in which attention is paid not to the average but to the extreme tendencies in the situation The purpose of an ideal construction is to provide an instrument for the measurement of reality In this way the roleless role of old people *today* is contrasted with their significant *role before* the industrial revolution

The effects of economic and social trends which catapulted old people from the family oriented rural society to the organization-centered urban society are still in operation The aging will continue to increase in numbers relatively as well as absolutely Years will be added to their life-span They will still feel insecure until the double threat of prolonged disability and of inflation can be lifted Older people will continue to depend less upon family and relatives for their support and social life and win their financial and social independence by the help of public and private organizations which are *taking over* first place in their lives The increase of leisure presents a problem first of how to fill it and second of how to use it *for self* expression and for community service There will still remain the most difficult [illegible]

functional value to the person and to society It will be interesting to find out in our survey *how far* the countries of Western culture are making progress toward this objective and what we may learn from their experience

IV Societal Concern for the Aging

This *volume* is primarily interested in the problems of aging in countries of Western culture and in what these countries are doing about them We have seen that the extended family is no longer a cohesive economic and social unit with the capacity to give adequate care to the aging The major responsibility for their welfare has now been taken over by government (national provincial or state, and municipal) and by private organizations (economic, social and cultural)

This intervention by government and private organizations has been a result of the concern of the public for the problems of the aging in the transition from a rural to an urban civilization The chapters in this book which follow deal with societal concern for the aging in nine different areas (1) population structure and trends, (2) employment and retirement, (3) income maintenance and medical insurance (4) housing and community services, (5) physical health and rehabilitation (6) mental health, (7) family structure and relationships, (8) beyond family and work, and (9) research

A Population Structure and Trends

In all countries of Western culture the increase in the proportion of the aging in the population has dramatized their present plight Yet this one statistic is not of much help as a basis for shaping policies and programs for the welfare of older people We should know much more

We need, first, to know the *position of the aging* in the population structure of each country We are interested in the relative proportions of the aging by sex to other age groups such as children youth early adult and middle-adult population

Second it is important to learn what the factors are that have been and now are affecting the proportion of the aging in the population What has been and is the relative effect on the number and proportion of older people of such changes as increasing or decreasing fertility, immigration and emigration and increase in life-expectancy?

It is necessary, in the third place, to study the trends in the proportion of the population in the different age and sex groups. The forecast of future trends depends in part upon the projection of past trends but even more upon an analysis of the factors which affect the proportion of old people in the total population.

The knowledge to be gained by a searching analysis of the structure and trends of the aging population is indispensable for an understanding of the problems of aging and in arriving at their solution. It has a direct bearing on formulating policies of employment and retirement of older workers. It is basic to the issues in income maintenance and housing in old age. It enables us to forecast the volume of care needed for physical illness and mental disorders in old age. It will affect in the future as it has in the past the nature of family organization and relationships. It is helpful in planning for leisure-time living in the later years.

B. Employment and Retirement

Employment, as we have seen, took on new meaning with the industrial revolution. It no longer meant working at home on the farm or in the shop under the direction of father or mother. It became typically laboring in the factory or the office, with hundreds and later thousands of employees organized into a working force by managers and supervisors.

It was in the context of this change in the nature of employment that the phenomenon of retirement was introduced. Previously in the familial stage of work there was no retirement from employment. The individual on his own volition gradually shortened his hours of work or changed from heavy to lighter work. As long as he was ambulatory he still had odd jobs or chores to do. Only with disabling illness did he stop working.

Retirement was introduced into industry along with pensions and old age insurance. It has taken various forms—optional, mandatory, flexible, etc. The age of retirement may be arbitrary (or one fixed age for all employees) or variable.

In the United States the policies and practices of retirement are in a state of controversy, confusion, and perplexity. A good look at European experience will be helpful in getting perspective on our own problems. Information is needed on the changing patterns of employment and retirement. What are the present trends, for example, in the duration of the work life of the person and of the lengthening period of retirement? Particularly, what is the role of the older workers in the nation's manpower resources? What do they do, and where do they work? How do they differ from younger workers by occupation, by productivity, by full-time or part-time work, and by self-employment?

What are the current practices and attitudes of government and business in employment of older workers? How do older persons adjust to new technological practices and attitudes? Are they able to learn new skills? What does the future hold for the employment of the older worker?

Are retirement policies and practices moving to a consensus, or are they tending to variability to meet individual differences in the worker and to take account of diversity in requirements of the work? Are there other trends that are emerging?

The examination of conditions and trends in European countries should throw light on the shaping of employment and retirement policies and programs in this country.

C. Income Maintenance and Medical Insurance

European governments have had longer experience than ours in the United States in meeting the economic needs of retired persons. We, of course, had the advantage of their experience in shaping our social security legislation. Our program of Old-Age and Survivors Insurance was, however, fashioned to meet the American sit-

uation and not copied from any one European country

Our survey of selected countries of Western culture provides the opportunity to compare differences in philosophy, policy, and practices It should enable us to discover trends both in actual operation and in their thinking about desirable changes to be made Especially valuable will be an examination of the recent legislation and proposals for legislation in countries like Denmark, Great Britain, Sweden, and West Germany

It is important so far as feasible to determine how far governmentally sponsored programs are the sole source of retirement income or how much it is augmented by savings insurance in private companies, dividends and interest, pension by employer, assistance from relatives and friends etc

Certain special problems of income maintenance merit particular investigation There is permanent disability which may begin before the older person reaches the age of eligibility for insurance benefits or pensions There is the nature and extent of assistance programs and how they articulate with and supplement insurance benefits and pensions The income maintenance of widows [illegible]

[illegible] methods of financing old age benefits and the present and future costs of old age security to the economy

One of our unsolved problems is that of an adequate program of insurance against medical expenses especially those of prolonged illness which cause the aging great anxiety For that reason European experience deserves special study Examination needs to be made not only of the provisions of their programs but of the success of their operation

D Housing and Community Services

In the past in countries of Western culture the conception of housing for older persons was very limited At first it was confined almost entirely to the indigent aging who had either no kinfolk or none who would take them into their homes The almshouse or poor farm provided by the community was the place of last resort and no return Old people's homes, under private and generally religious auspices, for the deserving aging were later established and carried less social stigma than the public institutions

Today the concept of housing for the aging has broadened to include provision for all older people It is also a more flexible concept, taking in a wide variety of forms of housing to meet the needs and interests of the aging of all social and economic classes of all the later ages, of all conditions of health, and of all individual preferences There is also more consideration of the residential cycle The residential cycle emphasizes the sequence of types of housing to meet the changing needs of older persons at particular stages of health and economic status in the later years

The survey of housing in selected countries of Western culture exhibits the present diversity of housing for older people There is independent living in bungalows, row houses, flats and apartments, retirement towns, etc. There are communal living arrangements, with dormitories, residence halls and several story apartment-like buildings There are special arrangements for medical care, general hospitals, geriatric hospitals, halfway houses, convalescent homes foster homes, etc.

Despite the diversity of housing design and facilities for the care of the aging, one central criterion is gaining recognition, namely that the housing arrangement must be as homelike as possible This criterion emphasizes the values of privacy, the retention of some household possessions linking the present with the past, and the minimizing of regulations and regimentation

Pioneering projects are appearing in various countries to enable older persons to remain in their own homes as long as possible Homemaking services and ' meals on

wheels" enable physically disabled persons to stay out of hospitals and homes for the aged The team of visiting physician, nurse, dietitian, and social worker makes it possible for many sick persons to be cared for in their own homes and thus frees hospital beds for those who require more specialized and intensive treatment European experience can offer much of value in our plans for development of community services

E Physical Health and Rehabilitation

In recent years in countries of Western culture entirely new conceptions of the physical health of the aging are supplanting those previously held The earlier notions tended to be pessimistic Aging was thought of as the period of biological decadence inevitably accompanied by degenerative diseases The emphasis was upon *geriatrics*, the treatment of the so called diseases of old age The prevailing attitude was one of hopelessness even among physicians Chronic illnesses and physical disabilities were frequently termed incurable Treatment was largely limited to custodial care and to remedial measures

Today the goal is rehabilitation and the restoration insofar as possible of the functioning of the individual Pilot projects have demonstrated the success of the new methods of physical re education in cases formerly considered hopeless Techniques have been developed of enlisting the co operation of the patient in putting forth his full effort in relearning impaired physical activities

The goal of physical health has become positive One aspect of this point of view is preventive Manifestations are modern sanitation, the protection of the water supply, sewage disposal systems, vaccination and innoculation programs, screening projects and regular physical examinations for the early detection of disease, etc

Another aspect of modern public health is educational Its purpose is the instruction of the public at all ages in practices that will achieve and maintain good health The principles of nutrition are well established but not generally known or practiced by the public The value of exercise and recreation are well known, but modern life has diminished active participation in games and sports Yet the maintenance of good health in the early and middle adult years is the best guaranty of its continuance in the later years

All countries of Western culture are concerned about the health of all their citizens It will be interesting to survey what is being accomplished in these countries in the treatment of diseases and disabilities and in programs of rehabilitation, prevention, and education for older people

F Mental Health

Mental health up to the present time, has been considered mainly on its negative side The chief interest has been in the care and treatment of mental illnesses, such as the psychoses and the neuroses This direction of attention was only to be expected with the apparent increase in mental disorder which came in the wake of the industrial revolution and the growth of cities

In the earlier period, when men and women worked as a family group on the farm or in villages and towns, there may well have been fewer mental breakdowns But, at any rate, the extended family cared for its members in mental illness and they were sent to the insane asylums of those days only as a last resort Even today the admission rate to mental institutions is less from rural than from urban areas

In countries of Western culture the last 100 years have seen a great development of the sciences of the human mind—psychology, psychiatry, and psychoanalysis The new knowledge gained by research has led to the development of the applied science of psychotherapy

More recently there have been discovered by medical science the so-called wonder drugs, which in experimental use have

produced marked improvement in many but not all mental patients The results already attained are promising for greater gains in the future Mention should also be made of the demonstration of successful use of shock treatment by electricity and certain drugs.

The main point is that mental hospitals need no longer be places of custodial care They are on the way to becoming like general hospitals, centers for successful medical and psychotherapeutic treatment. This transition is now in progress and is somewhat further advanced in some countries than in others

Older persons present two special problems as compared with younger people First many of them are suffering from senility and arteriosclerosis which do not yield to present methods of treatment Second in some countries many who are not psychotic or have only a temporary mental disturbance unwanted by relatives or without relatives are committed to mental hospitals

It would seem that the first group might in the great majority of cases be better cared for elsewhere than in mental hospitals They should be carefully screened before admission as should also the second group of the temporarily mentally disturbed to find out the best substitute arrangement Our survey of mental health in countries of Western culture will attempt to ascertain the extent to which pioneering ... the ... sect ... suited to their needs.

There remains the almost untouched field of insuring the positive mental health of the great majority of older people The approach here would seem partly psychotherapy in dealing with minor mental disturbances and anxieties It would be partly educational in disseminating the principles of good mental health. *But it* would also be preventive in attacking the conditions making for frustrations and anxieties, such as fear of retirement, loss of status when retired from employment, inadequate income, and anxiety about prolonged illness and inflation

G *Family Structure and Relationships*

The small family of husband, wife, and children of modern society is in striking contrast with the large three generation family living under one roof of the past Yet in countries of Western culture this change in social structure took place in recent times as a consequence of the industrial revolution and the growth of cities

First, we are *interested in knowing* the factors which brought about this change Several of them have already been discussed in this chapter They include technological changes in *farming*, the shift from the home to the factory as the place of work, the loss of the function of production by the family as a unit, the migration of the family to the city, and the entrance of women into industry All these changes combined to break up the large family and contributed to the emerging of its component autonomous units of husband, wife, and children

Second we wish to survey the evidence of the persistence of the extended family not as a housing unit but as a network of *relations* that still are significant in the lives of older people Under what conditions does the extended family survive no longer as a unit of economic production but as a unit of frequent social contacts and *reciprocal* services?

Third, what has been *the fate of older* people in their family relations as a result of these catastrophic changes? How has the breakup of the extended family ... upon the older man and his family? How have he, his wife, and his children *reacted to* the impact of these experiences? What effect have they had on relations of husband and wife, of parents and their adult children, and of grandparents and grandchildren?

Fourth, what are the *family relations* of those detached from the nuclear family, namely, the widowed, the single, and the divorced? The widowed and the single had a haven of refuge in the extended family of the past To what extent do they now associate with relatives or do they lead an isolated, lonely, and unhappy life in their old age?

Fifth, what changes are taking place in family relations in adjustment to the trends of modern life? Are these adjustments fur ther advanced in certain countries than in others?

Finally, in what ways may we in the United States profit by this survey of changing family structure and relationships in countries of Western culture?

H Beyond Family and Work

Many older men believe that life is real ly finished after the work career is over Many aging women feel that life is hardly worthwhile after they have reared a family and the children have left home to begin their careers Yet retirement living can be viewed by both men and women as an opportunity to begin a new career

This challenging conception of retirement is new and one that is just beginning to capture the imagination of older people and of gerontologists interested in their aspirations

There are of course obstacles to the realization of this vision of the possibilities in retirement living Some of these are in the minds of older people Others are in the difficulties of setting up the objective con ditions for the realization of the vision

Preretirement attitudes hamper both men and women Many men feel that only remunerative work will keep up their mo rale They reject the idea of retirement Many women want to continue living in the lives of their children and grandchil dren They also reject retirement as a new way of life

There are at present no approved and generally accepted patterns of retirement living Society and its institutions have not provided new roles to replace the old ones

Robert J Havighurst (1954) has outlined the basic roles by which adults gain self ex pression and recognition One of these, the work role is lost upon retirement In coun tries of Western culture the other roles—family member citizen church member, association member, friend user of leisure time and student—tend to contract for most older people One or more of these may almost cease to exist for some aging persons Nearly all of them change in their meaning and satisfaction for the retired person He may feel superfluous, pushed aside and crowded out in some groups in which he once played an active role Upon being retired from work, he may discover that he is being retired by his family, his church and his club Or for one reason or another, sometimes financial, sometimes psychological, he withdraws from one or more of these roles

One solution open to the older person is to join or to form groups with members of his own age These are beginning to mul tiply in countries of Western culture An other is for institutions such as the church and the school to re examine their function with reference to older people and to en gage in experiments designed to find vital activities for older people that will give new content to old roles in which the aging *will find recognition and fulfilment*

Particularly difficult is the problem of devising substitutes for the meaning which work has had The opportunities for re munerative employment for older men are continuing to decline What are the activi ties and roles in retirement that can re place the meaning of work for retired men? *Will our survey of the existing situation in* European countries give us clues to the an swers to this problem?

I Research

Action for the welfare of the aging preceded the rise of social gerontology, which

as a pure science, is the study of aging in its psychological and social aspects. In fact, research in social gerontology is recent both in the United States and in other countries of Western culture. The International Association of Gerontology held its first congress only 10 years ago. This past decade has witnessed the growth of research in social gerontology.

Research in aging has now reached the point where comparison of findings and methods in different countries are of increasing value. A first step is to survey the progress of research in selected European countries to ascertain the conditions which stimulated its development. Under what various auspices have investigations been carried on, and what have been the motivations for the research? To what extent have the studies been made by individual scholars or by the organization of large-scale studies?

A second step is to discover the topics of inquiry that have engaged the attention of European scholars. Have they been mainly of practical interest related to current policies and programs? Or have they concentrated rather on topics of basic scientific concern and on gaining new knowledge of the psychology and sociology of aging?

A third step is to inquire into the contributions which European studies have made to methods of research. What have we to gain in our techniques of inquiry by our survey of investigations already made or in progress in countries of Western culture?

V Conclusion

The comparative survey of aging and its problems in selected European countries is timely for the further development of social gerontology in the United States. I-
both r

fi

c

... in behalf of the aging has a longer history in the Old World than in the New. For example, the recognition of governmental responsibility for action to introduce old age insurance goes back to 1889, when Chancellor Bismarck instituted this program in Germany. Not until 46 years later by the distress of old people in the depression and the pressure of the Townsend Movement did the United States enact social security measures for its older citizens. Today, 25 years later, we are in a position to view our problems, policies, and programs in the light of the trends and developments in other countries of Western culture.

References

Barron, M. L. 1953 Minority group characteristics of the aged in American society. J Gerontol., 8, 477–82.

Bond, F., Baber, R. E., Vieg, J. A., Perry, L. B., Scaff, A. H., and Lee, L. J., Jr 1954 *Our needy aged* New York Henry Holt & Co.

Boulding, K. 1953 The organizational revolution New York Harper & Bros.

Burgess, E. W., and Locke, H. J. 1953 The family from institution to companionship New York 3 American Book Co.

Daric, J. 1953 Structures familiales comparées *In* G. Friedmann (ed.), Villes et campagnes civilisation urbain et civilisation rurale en France, pp 333-35 Paris Librairie Armand *Colin.*

Friedmann, E. A., and Havighurst, R. J. 1954 The meaning of work and retirement Chicago University of Chicago *Press*

Havighurst, R. J. 1954 Flexibility and the social roles of the retired. Am J Sociology, 59, 309–11

——— 1958 ...

Ingegnieros, S. 1958 Aspetti gerontologici milanese Milan Quaderni della "Citto di Milano"

International Association of Gerontology Committee on Social Research 1958 Cross national surveys of old age. Ann Arbor Division of Gerontology, University of Michigan.

INTERNATIONAL LABOUR OFFICE 1957 Year book of labour statistics, 1957 Geneva The Office

INTERNATIONAL MONETARY FUND 1957 International financial statistics, Vol 10 (October) Washington, D C The Fund

KONIG, R 1956 Changes in the Western family *In* INTERNATIONAL SOCIOLOGICAL ASSOCIATION, Transactions of the Third World Congress of Sociology, 4, 63–74 Amsterdam The Association

MOERS M 1953 Die Entwicklungsphases des menschenlichen Lebens Ratingen Aloys Henn Verlag

OGBURN, W F, and TIBBITTS, C 1933 The family and its functions *In* Recent social trends in the United States, 1, 661–708 New York McGraw Hill Book Co

SAUVY, A 1955 The historical and sociological basis of social policy and social problems *In* Old age in the modern world, pp 28–32 Edinburgh E & S Livingstone

SHELDON, J H 1955 The social philosophy of old age *In* Old age in the modern world, pp 15–26 Edinburgh E & S Livingstone

SPIEGELMAN, M 1955 An international comparison of mortality rates at the older ages *In* UNITED NATIONS, WORLD POPULATION CONFERENCE, Transactions of the World Population Conference, 1954 papers, 1, 289–309 New York United Nations

TARTLER, R 1957 Das Alter in der modernen Gesellschaft Stuttgart Ferdinand Enke

TOWNSEND, P 1957 The family life of old people Glencoe, Ill Free Press

UNITED NATIONS DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS 1956 The aging of populations and its economic and social implications ("Population Studies," No 26) New York United Nations

UNITED NATIONS ECONOMIC COMMISSION FOR EUROPE 1957–58 Economic survey of Europe New York United Nations

UNITED NATIONS STATISTICAL OFFICE 1955–58 Demographic yearbook New York United Nations

——— 1956–58 Statistical yearbook New York United Nations

WHYTE, W H 1956 The organization man New York Simon & Schuster

II

Population Structure and Trends

PHILIP M HAUSER AND RAUL VARGAS

I Introduction

passage of time and is subject to continuous increases until the person's ultimate demise

The age of a population, or an aggregation of persons, is not so simply determined It may be conceived as either the aggregate age of all its members as a frequency distribution of the age of its members, or by some measure of central tendency such as an arithmetic average or a median The age of an aggregation of persons is also unique to a population and changes with the course of time But unless the population is a closed one, that is subject neither to increase nor to decrease by reason of fertility, mortality, or migration the age of a population does not necessarily increase over time An aggregation of individuals subject to change

its various age components as a result of past as well as current changes in the com ponents of population change That is past changes in migration fertility, or mortality, in interaction with current changes in these events can affect the age structure of a population The "age' of a population is therefore a much more complex matter than the age of an individual

II Factors Affecting Age Structure

Recent studies, especially those by the United Nations, have added considerably to knowledge about the effects of changes in fertility, mortality, and migration on the age structure of a population It has been demonstrated, for example, that declines in the death rate have contributed little to changes in the age structure of populations, as compared with declines in the birth rate, and that these respective changes have different impact on the base (lower ages) and apex (older ages) of a population More-

specific course and stage of population change

In general, the reduction of fertility and

of old people If a lower level of fertility is maintained, the age structure tends to stabilize, but with a higher proportion of old people than that of the original population If fertility continues to drop to lower levels, the population will become older and older

A decline in death rates can produce different instantaneous effects, depending on the ages at which mortality reduction has taken place. If the decline is uniform

throughout the whole life span, there will be no instantaneous aging or rejuvenation, but the life expectancy will be increased, and an increase of older people should be expected to occur later on That is, aging would occur after some considerable passage of time If the decline of mortality occurs in the older ages, aging will be instantaneous, and the population will stay old as long as the new level of mortality is maintained, growing older if that level is reduced even more If the decline in mortality is in the younger ages, there will be an instantaneous rejuvenation of the population, but, as the life-expectancy is increased, more people will be kept alive to reach older ages, and aging occurs in the long run

The combined effect of the reduction of fertility and mortality is inevitably the aging of a population, and this is the situation in all the relatively aged countries of the world

Migration, unfortunately, is a demographic variable more difficult to measure, and the data available are scarce and incomplete In general, the evidence is that the effects of migration on the aging of a population are relatively unimportant as compared with the effects of declining fertility or mortality In the case of a country of emigration, the effect would be null only under the assumption that the migrants constitute a representative sample of the country's population—a random sample in the case of large emigration Most of the time this is not the case, for migration is highly selective by a series of characteristics, including age If the median age of the emigrants is lower than the median age of the whole population, migration will produce instantaneous aging, especially if the migration rate is high and mortality and fertility remain constant During the process there will be a trend to successive aging and rejuvenation as the survivors of successive cohorts reach older ages This oscillating trend can be detected, moreover, only if the rate of emigration is quite high If the emigration has been highly selective by some trait, differential aging with respect to this trait could better be detected than total aging of the population

In the case of a country of immigration the results are inverse There would be *aging* or rejuvenation only insofar as the migrants would be younger or older than the country's population Most of the time the median age of migrants is lower than the median age of the population Therefore, the impact of immigration is reflected in an instantaneous rejuvenation, and the aging process is retarded This fact is perceptible only in countries with high immigration rates The selectiveness of migration, moreover, makes conclusion difficult More research is needed in this area to permit definitive generalization

Before focusing on trends in the age structure of the United States and selected European populations, let us examine the population structures and vital rates of various parts of the world in the light of which our own and European patterns of aging can be better understood Table 1 presents statistics relating to the age structure, fertility, and mortality of some seventy two countries

As a basis for comparing the "age" of these populations, the proportion of the population 65 years of age and older is shown in accordance with conventional usage It may be observed that there is considerable variability in the populations of older persons in these seventy two nations The extremes are represented by Togoland, with only 1 5 per cent of her population 65 and over, and by France, with 11 8 per cent in this age range

The United Nations in its analysis of the age structure of the nations of the world has arbitrarily defined populations as "young," "mature," and "aged" The young are nations with less than 4 per cent of their people 65 years and older, the mature, with 4–7 per cent, and the aged, with over 7 per cent It is instructive to examine the characteristics of the countries which fall into these respective groupings

The young countries are without exception the economically less developed coun

TABLE 1*

TOTAL POPULATION, BROAD AGE STRUCTURE, CRUDE BIRTH RATE, CRUDE DEATH RATE, AND LIFE EXPECTATION AT BIRTH FOR SEVENTY TWO COUNTRIES IN OR AROUND 1950

Country	Year of Census or Estimate	Population (000 s)	Broad Age Structure (Per Cent of Population)			1950 Crude Birth Rate	1950 Crude Death Rate	Life Expectancy at Birth, 1950	
			Under 15	15–64	65 and Over			Male	Female
France	1950						12.8	63.6	69.3
Belgium	1950						12.5	62.0	67.3
Great Britain	1951						11.7	67.3	72.4
Ireland	1951						12.7	60.5	62.4
Sweden	1950						10.0	69.0	71.6
Austria	1951						12.4	61.9	67.0
West Germany	1950						10.4	64.6	68.5
Norway	1950						9.1	69.2	72.6
New Zealand (excluding Maoris)	1951	1,822.4	28.38	62.04	9.58	24.7	9.3	68.2	72.4
Switzerland	1950	4,814.5	23.63	66.80	9.57	18.1	10.1	62.7†	67.0†
East Germany	1946	17,313.7	24.92	65.80	9.28	‡	‡	‡	‡
Denmark	1950	4,281.1	26.34	64.55	9.11	18.6	9.2	67.8	70.1
United States	1950	150,696.0	27.15	64.67	8.18	23.5	9.6	65.5	71.0
Italy	1950	46,279.4	26.34	65.60	8.06	19.6	9.8	‡	‡
Australia	1951	8,431.3	27.06	64.92	8.02	23.3	9.6	66.1	70.6
Netherlands	1951	10,264.5	29.48	62.66	7.86	22.7	7.5	70.6	72.9
Canada	1951	14,009.5	30.34	61.91	7.75	27.1	9.0	66.3	70.8
Czechoslovakia	1947	12,146.6	24.34	68.08	7.58	23.3	11.5	‡	‡
Iceland	1950	143.6	30.85	61.63	7.52	28.7	7.9	60.9†	65.6†
Spain	1950	27,963.1	26.23	66.54	7.23	20.2	10.9	47.1†	53.2†
Portugal	1950	8,441.2	29.47	63.55	6.98	24.4	12.2	55.5	60.5
Hungary	1941	9,315.1	25.98	67.05	6.97	21.0	11.5	54.9†	58.2†
Soviet Union	1939	169,486.3	36.20	56.90	6.90	‡	‡	‡	‡
Finland	1950	4,028.0	30.00	63.38	6.62	21.5	10.1	58.6	65.9
Greece	1930	7,344.8	32.99	60.70	6.31	‡	‡	‡	‡
Basutoland	1946	557.7	37.83	55.93	6.24	‡	‡	‡	‡
Union of South Africa (European)	1946	2,371.3	30.49	63.33	6.18	25.1	8.7	63.8	68.3
Yugoslavia	1951	16,339.3	30.82	63.51	5.67	30.3	13.2	‡	‡
Poland	1949	24,160.0	28.37	66.55	5.08	30.5	11.6	55.6	62.5
Japan	1950	83,165.0	35.42	59.64	4.94	28.2	10.9	61.9	65.7
Peru	1949	7,424.5	42.08	53.60	4.32	32.3	12.5	‡	‡
Trinidad and Tobago	1950	632.5	39.58	56.31	4.11	37.5	12.2	56.3	58.4
Haiti	1950	3,086.1	38.02	57.98	4.00	‡	‡	‡	‡
Israel	1951	1,323.9	30.48	65.52	4.00	33.0	6.5	67.5	70.5
British Guiana	1946	369.3	37.72	58.29	3.99	40.4	14.6	49.3	52.5
Honduras	1950	1,503.5	40.58	55.45	3.97	40.4	12.0	‡	‡
Jamaica	1949	1,371.2	35.97	60.11	3.92	30.0	11.9	55.7	58.9
Argentina	1947	15,828.7	30.85	26.93	3.92	25.5	9.0	56.9	61.4
Puerto Rico	1950	2,212.0	43.12	53.08	3.80	39.0	9.9	‡	‡
Paraguay	1950	1,328.1	43.77	52.51	3.72	‡	‡	‡	‡
South Korea	1952	19,410.6	41.09	55.21	3.70	‡	9.1	47.2†	50.6†
Alaska	1950	128.7	26.46	69.85	3.69	27.2	9.1	‡	‡
Union of South Africa (non European)	1946	9,014.7	39.52	56.84	3.64	‡	‡	50.7	49.8
India	1951	356,798.7	37.45	58.97	3.58	21.9	16.1	32.4	31.7
Ecuador	1950	3,201.8	42.46	54.00	3.54	47.3	17.7	50.4	53.7
Chile	1948	5,621.0	37.21	59.29	3.50	32.4	15.7	49.8	53.9

* Source United Nations *Demographic Yearbooks*

† In or around 1950

‡ Data not available

TABLE 1—*Continued*

Country	Year of Census or Estimate	Population (000's)	Broad Age Structure (Per Cent of Population)			1950 Crude Birth Rate	1950 Crude Death Rate	Life Expectancy at Birth, 1950	
			Under 15	15–64	65 and Over			Male	Female
Ceylon . .	1947	6,878 9	37 15	59 37	3 48	40 4	12 6	57 6	55 5
Turkey ..	1950	20,860 2	38 04	58 55	3 41	‡	‡	‡	‡
Mexico	1950	25,743 7	41 78	54 86	3 36	46 0	16 2	37 9†	39 8†
Cuba	1943	4,778 4	36 40	60 26	3 34	28 3	7 5	‡	‡
Panama	1950	755 3	41 62	55 02	3 33	33 3	9 6	50 5†	53 5†
Malaya	1947	2,202 1	41 29	55 50	3 21	42 0	15 8	‡	‡
Philippines	1948	19,233 6	44 17	52 68	3 15	21 9	8 2	‡	‡
Egypt	1947	18,908 4	38 07	58 83	3 10	44 4	19 1	35 6	41 5
El Salvador	1950	1,854 6	41 16	55 88	2 96	48 5	14 7	49 9	52 4
Angola .	1940	3,728 3	40 41	56 66	2 93	‡	‡	‡	‡
Colombia	1950	11,254 1	42 01	55 09	2 90	36 7	14 2	‡	‡
Costa Rica	1950	800 2	42 87	54 24	2 89	46 5	12 2	‡	‡
Dominican Republic	1950	2,135 7	44 50	52 64	2 86	37 2	10 0	‡	‡
Nicaragua	1950	1,056 9	43 28	53 87	2 85	41 2	10 8	‡	‡
Burma	1954	18,597 3	37 42	59 75	2 83	46 1	39 3	‡	‡
Algeria (Moslems)	1948	7,554 0	43 02	54 28	2 70	39 5	‡	‡	‡
Venezuela	1950	5,026 8	41 96	55 38	2 66	42 6	10 9	‡	‡
Guatemala	1950	2,784 2	43 63	53 76	2 61	50 9	21 9	‡	‡
Thailand	1947	17,432 1	42 32	55 10	2 58	28 4	10 0	48 7	51 9
New Zealand (Maoris)	1951	115 4	46 49	50 97	2 54	45 1	12 1	54 0	55 9
Formosa	1950	7,554 6	41 41	56 09	2 50	42 5	11 3	50 4	53 7
Brazil	*1950*	*51,827 8*	*41 86*	*55 69*	*2 45*	‡	‡	‡	‡
Mozambique	1940	5,085 3	43 46	54 30	2 24	33 9	6 1	‡	‡
Greenland	1945	21 4	42 65	55 18	2 17	49 4	25 0	‡	‡
Gold Coast	1950	3,869 2	36 53	61 95	1 52	30 7	21 3	‡	‡
Togoland	*1950*	*397 4*	*35 45*	*63 09*	*1 46*	‡	‡	‡	‡

tries of the world. *They are largely in Asia,* South America, and Africa and are predominantly agricultural nations. These countries *include most of the world's population, for* the data which are available indicate that China, with almost a fourth of the world's *population, although not shown in the table,* also falls into this group.

The young nations, it is to be observed, *have general or crude birth rates mostly* above 30 (twenty-five of the thirty-seven); and almost half above 40 (sixteen of them). *The median crude birth rate of these na*tions, as reported, is 40. Moreover, the young nations have relatively high general death rates, *although the incompleteness of* death registration distorts the available data and makes a definitive statement difficult. *The median expectation of life for females* in this group of nations for which such data are available is 53 years.

The *mature nations*, by the United Nations classification, include those still in rapid industrial transition, such as the U.S.S.R. and Japan, *and, in general,* nations relatively favorably situated in respect of national income per head in comparison *with the young nations* The Communist countries of eastern Europe are heavily represented in this group, as are also the *relatively less economically developed European* nations The birth rates of these countries are relatively high, with a median of 29. The *death rate is lower than in the young na*tions, and, although the statistics are inadequate, the median expectation of life at birth *for females*, reported as 64 years for the nations for which they are available, is undoubtedly indicative of better mortality conditions than obtains among the younger countries.

The aged nations in Table 1 are, on the

whole, the economically more developed nations of the world They are entirely drawn from Europe or from areas mainly settled by Europeans in North America and Oceania They constitute but a small portion of the world's total population Their general birth rates, although boosted by post-World War II conditions, are relatively low, with a median birth rate, as shown in Table 1, of 20 Their death rates are also relatively low, as indicated by a median expectation of life 71 years for females Their most important common characteristic, as will be demonstrated, is undoubtedly found in their sharing of a declining birth rate over a relatively long period of time

It is to be noted that the United States, while among the aged nations, is fairly well down the list With 8 2 per cent persons 65 years old and over, the United States is below the midpoint of the group In general, it is the northern and western European nations which are the most aged

This overview of the age structure of the nations of the world for which reasonably satisfactory data are available permits sev- [illegible]

presence of a relat vely large [illegible]

a [illegible]

t [illegible]

aged nations are the most economically advanced nations, these are, also, the nations with the lowest birth and death rates Fourth the *problems of an* aged population are relatively new problems and apparently are among the by products of economic development which characterizes Western civilization

In the materials which follow, we shall focus on the age structure of the United States and selected *European nations* and the factors associated with changes in the age structure

III Aging in Selected Countries

The *twenty aged* countries listed at the top of Table 1 have not always *been aged.* Aging, however, has been a continuous process in these countries, over the period for which census statistics are available The scope of this paper and the availability of census statistics make an exhaustive analysis of the aging process in all aged countries impossible Nine countries have been selected for consideration, namely, France, the United Kingdom, Sweden, West Germany, the Netherlands, Italy, Czechoslovakia, Canada, and the United States Analysis of the data for these countries will serve to illustrate the process and disclose the factors which have been involved

In the following presentation certain limitations must be borne *in mind* (1) *even* though the countries considered possess the best census and vital statistics, *the data are,* nevertheless, far from adequate, and especially is this the case *for the historical data;* (2) because the data have improved over time, and differentially *among countries,* comparability for the same country, *as well* as between countries, at a given year is adversely *affected* For *these* reasons the figures that are presented must be regarded as [illegible]

[illegible] countries make the figures *not strictly* comparable geographically in some instances *In the case of Germany,* for example, all the information refers to pre-*war Germany,* except for 1950, when it re-*fers to West* Germany only

A Population 65 Years and Over

Except for Fra[illegible]

[illegible] population *65 years* of age and over increased rapidly between 1850 *and* 1900, remained on a plateau of a little over 8 [illegible]

rc [illegible]

o [illegible] rose *rapidly from* the mid-nineteenth *century to 1890,* remained at about the same level of somewhat over 8 *per cent* for two decades to 1910, and then resumed its increase For the other seven selected nations, however, including the United States, *the rapid* increase in propor-

tion of senior citizens 65 or over took place mainly after the turn of the century Especially rapid in each of the nations under consideration has been the increase in proportion of older persons since 1920

The proportion of females 65 and over, with a few exceptions, exceeds that for males over the years in each of the countries considered Only in Italy over four census dates, a rise over previous decades It is not too easy to generalize about the differences in these ratios of the proportion of older females to that of older males because they result from a combination of influences, including selective migration and differential war losses, as well as differences in historical and current fertility and differential mortality in the countries

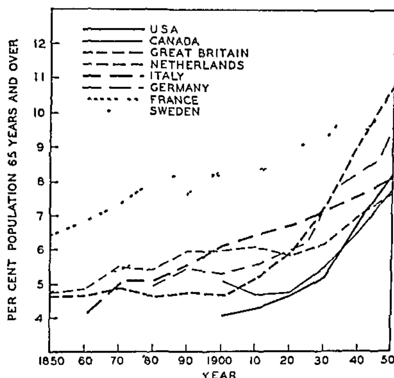


FIG 1 —Percentage of population 65 years old and over for eight selected countries 1849 1951

mainly before 1900, and in Canada in 1951 does the ratio of the proportion of older females fall below that of older males As an extreme case, almost 14 per cent of the females in France were reported 65 and over in 1950, as contrasted with less than 10 per cent males In France the ratio of the population of senior females to that of males was 1 42 The next largest ratios occur in England (1 33) and Czechoslovakia (1 23) Canada, with a ratio of 0 99, a somewhat larger proportion of older males than older females in 1951, shows the effects of selective male immigration over recent years In the United States the excess of older females was indicated by a ratio of 1 10, which represented

B Relation of Older to Younger Population

An examination of the relation of older population to various age categories of the younger population reveals interesting differences among the nations studied These relationships are presented in Table 3 and Figure 2 In the first block of this table the conventional old age dependency ratio is shown that is the number of persons 65 years of age and older for each 100 persons of working age, taken as the population 15–64 years old

In 1950 the old age dependency ratios in the nine countries ranged from 11 3 in

TABLE 2*

PERCENTAGE OF POPULATION 65 YEARS OLD AND OVER BY SEX FOR NINE SELECTED COUNTRIES IN OR ABOUT GIVEN YEAR

Country	1850	1860	1870	1880	1890	1900	1910	1920	1930	1940	1950
Both Sexes											
France	6 47	6 89	7 41	8 11	8 28	8 20	8 36	9 05	9 35		11 80
United Kingdom	4 64	4 68	4 79	4 62	4 77	4 69	5 22	6 03	7 40	8 97	10 83
Sweden	4 78	5 22	5 43	5 90	7 68	8 37	8 44	8 40	9 20	9 41	10 31
Germany†				4 72	5 10	4 88	5 04	5 77	7 36		9 27
United States						4 07	4 30	5 67	5 41	6 85	8 14
Italy		4 19	5 11	5 12		6 16	6 50	6 75		7 43	
Canada						5 07	4 66	4 78	5 56	6 67	7 76
Netherlands	4 75	4 89	5 52	5 45	6 01	6 01	6 12	5 88	6 21	7 01	7 73
Czechoslovakia									6 60		7 58
Male											
France	6 06	6 15	7 06	7 80	7 92	7 63	7 61	8 23	8 30		9 68
United Kingdom	4 28	4 31	4 44	4 24	4 31	4 18	4 63	5 40	6 65	8 03	9 26
Sweden	3 94	4 39	4 56	5 13	6 98	7 60	7 62	7 58	8 38	8 68	9 70
Germany†				4 46	4 71	4 42	4 47	5 27	6 89		8 91
United States						4 03	4 21	4 62	5 35	6 67	7 75
Italy		4 21	5 20	5 22		6 16	6 54	6 72		7 15	
Canada						5 06	4 47	4 75	5 48	6 62	7 78
Netherlands	4 26	4 33	5 01	4 99	5 55	5 59	5 76	5 55	5 93	6 71	7 42
Czechoslovakia									6 06		6 81
Female											
France	6 89	7 23	7 75	8 38	8 65	[illegible]	[illegible]	[illegible]			
United Kingdom	5 02	5 02	5 11	4 99	5 20						
Sweden	5 60	5 99	6 16	6 59	8 35						
Germany†				4 96	5 48						
United States											
Italy		4 14	5 00	5 03							
Canada											
Netherlands	5 21	5 42	6 00	5 91	6 44		[illegible]	[illegible]	6 46	7 29	8 04
Czechoslovakia									7 10		8 43
Sex Ratio (Older Females per 100 Older Males)											
France	114	118	110	107	109	115	119	119	124		142
United Kingdom	117	116	115	118	121	123	125	123	122	113	133
Sweden	142	115	135	123	120	119	121	121	119	116	113
Germany†				111	116	121	125	118	113		108
United States						102	105	102	102	105	110
Italy		98	98	96		101	99	101		108	
Canada						100	109	103	103	102	99
Netherlands	122	125	120	118	116	115	113	112	109	109	108
Czechoslovakia									117		123

* Source United Nations *The Aging of Populations and Its Economic and Social Implications* ("Population Studies" No. 26 [New York United Nations, 1956])

† West Germany in 1950

TABLE 3*

Old Age Dependency Ratio and Ratio of Population 65 Years of Age and Over to Younger Population Groups for Nine Selected Countries, 1900–1950

Country	1900	1910	1920	1930	1940	1950
	Old Age Dependency Ratio (Persons 65 Years and Over per 100 Persons 15–64 Years)					
France	12 5	12 7	13 3	13 8		17 7
United Kingdom	7 4	8 2	9 1	10 8	12 9	16 2
Sweden	14 1	14 1	13 5	13 9	13 4	15 6
Germany†	8 1	8 3	8 5	10 6		13 8
United States	6 6	6 8	7 4	8 3	10 1	12 5
Italy	10 3	10 9	10 9		12 0	12 1
Canada	8 4	7 5	7 9	8 9	10 2	12 5
Netherlands	10 2		9 6	9 8	10 8	12 3
Czechoslovakia				9 8		11 3
	Persons 65 Years and Over per 100 Persons 45–64 Years of Age					
France	40 2	40 4	39 6	41 7		49 0
United Kingdom	31 6	32 4	31 4	34 4	39 9	45 1
Sweden	49 2	48 3	48 0	48 8	43 7	44 8
Germany†	31 9	32 9	30 1	35 1		38 5
United States	29 6	29 4	28 9	31 0	34 6	40 0
Italy	35 1	37 2	38 8		42 3	
Canada	36 2	33 2	31 8	33 2	35 8	43 7
Netherlands	38 6		36 5	36 3	38 3	40 3
Czechoslovakia				36 6		36 7
	Persons 65 Years and Over per 100 Children 0–14 Years of Age					
France	31 4	32 4	39 8	40 7		54 4
United Kingdom	14 4	16 9	21 6	30 6	42 0	48 2
Sweden	29 1	30 3	32 6	41 7	50 9	47 9
Germany†	14 0	14 8	22 2	31 3		39 4
United States	11 8	13 4	14 7	18 4	27 4	30 3
Italy	18 0	19 1	21 6		24 2	29 7
Canada	14 7	14 1	13 9	17 6	24 0	25 6
Netherlands	17 3		16 7	19 0	23 5	21 6
Czechoslovakia				25 1		30 4

* Source United Nations, *The Aging of Populations and Its Economic and Social Implications* ("Population Studies, No. 26 [New York United Nations, 1956])

† West Germany in 1950

Czechoslovakia to 17 7 in France. The United States had a relatively low old age dependency ratio of 12 5 persons 65 and over for each 100 persons 15–64 Between 1900 and 1950 the greatest increase, absolute and relative, in the old age dependency ratio occurred in the United Kingdom There the ratio increased from 7 4 to 16 2, or more than doubled The next greatest increase in the old age dependency ratio during the first half of this century was that in the United States, which increased from 6 6 to 12 5, or almost doubled

pendency during the twentieth century took place after 1930

The old age dependency ratio is conventionally used largely for evaluating the economic burden of old age It and the ratio of older population to other segments of the

over to persons 45–64 or to youngsters under 15 may conceivably have some implications for the conservatism of a society, for opportunity for younger persons to achieve

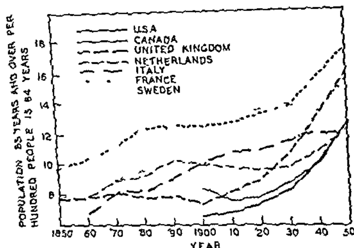


FIG 2 —Old age dependency ratios for eight selected countries, 1850–1950

In the United Kingdom, between 1900

age dependency ratio of 14 1 by 1900, the increase in the first half of the century was only 1 5 older persons per 100 persons of working age The United States ranked second only to the United Kingdom in absolute increase in dependency between 1900 and 1950 adding 5 9 senior citizens to her population for each 100 persons of working age It is to be observed that most of the increase in old age dependency which occurred during the first half of this century took place since 1930. Among the countries shown, seven tenths of all the increase in old age de-

advancement, and for the patterning of many types of activities, including education, religion, recreation, and consumption. In the absence of adequate knowledge grounded on research, most of what can be said about these relationships at this time is necessarily speculative But it is worth noting the great variations among the countries in these ratios

In the second block of Table 3 the number of persons 65 and over per 100 persons 45–64 years of age is shown Again France has the highest ratio, with 49 persons 65 and over, for each 100 of intermediate age 45–64 Czechoslovakia, at the other extreme, has only 37 older persons per 100 of intermediate age The United States, with 40 older persons per 100 of intermediate age,

is among the lowest of the countries in this respect, exceeding only West Germany and Czechoslovakia in this index

The historical data indicate that France and Sweden were the first of the countries to achieve relatively large numbers of older persons in relation to those of intermediate age In 1900, Sweden's ratio of old to intermediate population exceeded that of France, reflecting probably the results of relatively heavy emigration in the late nineteenth century With the decline in emigration, it has actually declined since

Throughout most of the first half of this century the United States had the lowest ratio of older persons to those of intermedi ate age among these nations It was the rela tively great increase in this ratio in the United States between 1940 and 1950 that placed the United States above West Germany and Czechoslovakia, as indicated above It is possible that, in consequence, persons of relatively vigorous intermediate age were able to rise to positions of leadership more readily in the United States than in the other nations during this critical period of world history

The ratio of persons 65 and over to those under 15 varies even more markedly than the indexes reported above France, in 1950, had 54 older persons for each 100 children, in contrast, the Netherlands had fewer than 25, and Canada, a little over 25 aged for each 100 children The United States had 30 older persons per 100 children in 1950 In 1900 the United States had fewer than 12 older persons per 100 children under 15, and Germany and the United Kingdom each had only 14 Most of the increase in the ratio of older persons to children among these nations which has occurred since 1900 has, except for Sweden and Germany, taken place since 1930 Over three fourths of the

1950 The other nations showed increases during the same period which ranged be tween these figures, except for Sweden and Germany

C Differential Rates of Increase of Age Groups

The relationships examined above arise from the difference in rates of increase among the age groupings of the populations These are given on an annualized basis, for countries for which they could be calculated in Table 4, which presents rates of increase (geometric rates) of persons 65 and over in comparison with rates of increase of persons under 65, by decade since 1900 and by half-century since 1850

For each of the six countries, persons 65 and over increased more rapidly than persons under 65 during the first half of this cen tury With few exceptions, this also tended to be true for each country in each decade Canada and the United States had the fast est growing older populations between 1900 and 1950, with annual rates of increase of 2 8, France and Sweden had the lowest rates of increase in older population, 0 9 and 1 1, respectively The fact that France and Sweden with the highest proportions of aged had slower growing older population than Canada and the United States may seem contradictory on first examination But the differences in rates of growth of older popu lation is partly a result of the differences in rate of total population growth, which has been much greater in the latter than the former countries Canada and the United States experienced total population increases of 2 0 per cent per year and 1 4 per cent per year, in contrast with France's 0 2 per cent and Sweden's 0 6 per cent per year during the first half of the century

France and Sweden's relatively high pro portion of older persons results from the fact that the rate of growth of older population in the former countries greatly exceeded that of the growth of their younger popula tion Although the older population also grew more rapidly in Canada and the United States, the ratio of older growth to younger growth was not so high in these countries as in France and Sweden This is docu mented in Table 5, which presents the ratio

of growth of older population to younger population

Between 1900 and 1950 the rate of growth of persons 65 and over in France was over nine times that of the population under 65 In contrast, in the United States the older population grew a little more than twice as fast as the younger, in Canada, only one and a half times as fast

Older population in Sweden grew only twice as fast as younger population in the first half of this century But it is to be remembered, as shown above, that aging began earlier in Sweden than in the other countries Between 1850 and 1900, Swedish older population grew almost three times as fast (2 7) as her younger population, a rate certainly above that of the United States and Canada for that period although below that of France

For the age structure of a population to remain unchanged, it is necessary that each age group grow at the same rate as total population growth If the older population grows more rapidly than the younger population, the age structure changes in the direction of older age The relationship between the rate of growth of the aged population and the younger population, or, more precisely, the departure from unity of this

TABLE 4

ANNUAL RATE OF INCREASE (GEOMETRIC) OF THE POPULATION 65 YEARS OLD AND OVER AND UNDER 65 FOR SIX SELECTED COUNTRIES BY DECADE 1900–1950, AND BY HALF CENTURY, 1850–1950

Country	Rate of Increase during Given Decade					Rate of Increase during Given Half Century	
	1900–1910	1910–20	1920–30	1930–40	1940–50	1850–1900	1900–1950
France							
All ages	20	− 10	61	10		14	18
Under 65	18	− 17	61	− 06		10	10
65 and over	41	70	94	1 33		61	93
United Kingdom							
All ages	99	46	45	47	38	1 16	56
Under 65	93	38	32	27	23	1 16	42
65 and over	2 10	1 92	2 53	2 93	1 98	1 17	2 25
Sweden							
All ages	73	67	39	37	1 01	78	63
Under 65	72	68	31	35	91	70	59
65 and over	81	63	1 33	57	1 95	1 91	1 06
United States							
All ages	1 93	1 41	1 51	71	1 36	†	1 38
Under 65	1 91	1 37	1 44	35	1 22	†	1 30
65 and over	2 51	2 25	3 01	3 12	3 13	†	2 80
Canada							
All ages	3 02	2 03	1 70	1 03	1 98	†	1 95
Under 65	3 07	2 02	1 61	91	1 87	†	1 89
65 and over	2 16	2 31	3 23	2 90	3 54	†	2 83
Netherlands							
All ages	1 39	1 45	1 46	1 18	1 26	1 03	1 35
Under 65	1 37	1 48	1 43	1 09	1 18	1 00	1 35
65 and over	1 58	1 09	1 99	2 42	2 27	1 51	1 85

* Source United Nations, *The Aging of Populations and Its Economic and Social Implications* ("Population Studies, No 26 [New York United Nations, 1956])

† Data not available

is among the lowest of the countries in this respect, exceeding only West Germany and Czechoslovakia in this index

The historical data indicate that France and Sweden were the first of the countries to achieve relatively large numbers of older persons in relation to those of intermediate age In 1900, Sweden's ratio of old to intermediate population exceeded that of France, reflecting probably the results of relatively heavy emigration in the late nineteenth century With the decline in emigration it has actually declined since

Throughout most of the first half of this century the United States had the lowest ratio of older persons to those of intermediate age among these nations It was the relatively great increase in this ratio in the United States between 1940 and 1950 that placed the United States above West Germany and Czechoslovakia, as indicated above It is possible that, in consequence, persons of relatively vigorous intermediate age were able to rise to positions of leadership more readily in the United States than in the other nations during this critical period of world history

The ratio of persons 65 and over to those under 15 varies even more markedly than the indexes reported above France, in 1950, had 54 older persons for each 100 children, in contrast, the Netherlands had fewer than 25, and Canada, a little over 25 aged for each 100 children The United States had 30 older persons per 100 children in 1950 In 1900 the United States had fewer than 12 older persons per 100 children under 15, and Germany and the United Kingdom each had only 14 Most of the increase in the ratio of older persons to children among these nations which has occurred since 1900 has, except for Sweden and Germany, taken place since 1930 Over three fourths of the increase which occurred in the Netherlands, and over half that in the United Kingdom, took place in the 20 years between 1930 and 1950 The other nations showed increases during the same period which ranged between these figures, except for Sweden and Germany

C Differential Rates of Increase of Age Groups

The relationships examined above arise from the difference in rates of increase among the age groupings of the populations These are given on an annualized basis, for countries for which they could be calculated, in Table 4, which presents rates of increase (geometric rates) of persons 65 and over in comparison with rates of increase of persons under 65, by decade since 1900 and by half century since 1850

For each of the six countries, persons 65 and over increased more rapidly than persons under 65 during the first half of this century With few exceptions, this also tended to be true for each country in each decade Canada and the United States had the fastest growing older populations between 1900 and 1950, with annual rates of increase of 2 8, France and Sweden had the lowest rates of increase in older population, 0 9 and 1 1, respectively The fact that France and Sweden with the highest proportions of aged had slower growing older population than Canada and the United States may seem contradictory on first examination But the differences in rates of growth of older population is partly a result of the differences in rate of total population growth, which has been much greater in the latter than the former countries Canada and the United States experienced total population increases of 2 0 per cent per year and 1 4 per cent per year, in contrast with France's 0 2 per cent and Sweden's 0 6 per cent per year during the first half of the century

France and Sweden's relatively high proportion of older persons results from the fact that the rate of growth of older population in the former countries greatly exceeded that of the growth of their younger population Although the older population also grew more rapidly in Canada and the United States, the ratio of older growth to younger growth was not so high in these countries as in France and Sweden This is documented in Table 5, which presents the ratio

experienced declines in mortality to reach the low levels shown for 1950–54, ranging from 7 5 for the Netherlands to 12 7 for France In general, it may be stated that the death rates for these nations all of them relatively economically advanced, are low The differences in the crude death rates among these countries reflect differences in age structure as well as differences in mortality conditions For example, the higher death rate in France in 1950–54 than in the Netherlands is partly attributable to the difference in the median age of these countries 35 years and 28 years respectively, in 1950

per cent at age 65, in contrast with an increase of 37 per cent at birth Roughly parallel increases were experienced by each of these Western nations during the first half of the century However, it may be observed that the highest expectation of life at birth in or around 1950 is found in the Netherlands and the lowest in France Moreover,

is not inconsistent with the fact that France has, by far, the higher population of older persons

Other conclusions of a general nature

TABLE 6

CRUDE DEATH RATES FOR NINE SELECTED COUNTRIES 1905 54
(Five Year Averages)

Country	1905–9	1911 13	1915 19	1920–24	1925 29	1930–34	1935 39	1940–44	1945 49	1950–54
France	19 5	19 0	19 2	17 3	17 3	16 0	15 7	17 9	13 9	12 7
United Kingdom	†	14 2	†	12 5	12 5	12 2	12 2	12 2	11 5	11 7
Sweden	14 6	13 9	†	12 4	12 1	11 7	11 7	10 8	10 4	9 7
Germany‡	18 3	14 8	†	13 9	11 9	11 0	11 9	12 2	11 0	10 6
United States	15 4	13 9§	14 5	12 0	11 8	11 0	11 0	10 5	9 9	9 5
Italy	21 7	19 3	†	17 5	16 6	14 1	13 9	14 5	11 7	9 8
Canada	†	†	†	12 3	11 1	10 0	9 8	9 8	9 4	8 7
Netherlands	14 7	13 1	†	11 0	10 0	9 0	8 7	10 3	9 4	7 5
Czechoslovakia	24 1	20 4	†	16 5	15 2	13 7	13 2	14 3	13 6	†

* Source United Nations, *Demographic Yearbook* League of Nations *Statistical Year book, 1940*
† Data not available
‡ West Germany from 1945 to 1954.
§ For the period 1910–14

A better comparison of differential mortality among these countries is afforded in Table 7 in which life-expectancy is shown by sex at selected ages.

Life-expectancy at birth has materially improved in each of these countries during the course of this century In the United States for example expectation of life at birth for males between 1900–1902 and 1949 51 increased from about 48 years to 65 years and for females from 51 to 71 years. Increases in life-expectancy at older ages have been less spectacular For males in the United States for example life-expectancy increased by 23 per cent at age 20 11 4 per cent at age 40 and only 10 8

which may affect the structure of a population may be reached from a study of life-expectancy Most of the gain which has been achieved in mortality has occurred at the younger ages and especially at infancy—that is mortality under 1 year of age Female expectation of life is greater than that of male, and the gap seems to be increasing with improvement in longevity The span of life, that is, the actual length that the human body can survive

that has increased.

With these considerations in mind with respect to mortality, let us turn next to a

relationship, may thus be taken as an index of the intensity of aging Further examination of Table 5, then, permits the following conclusions France has been aging more rapidly than any of the other five countries during the course of this century, while the Netherlands has been aging most slowly The United States between 1900 and 1950 aged less rapidly than France or the United Kingdom but more rapidly than the Netherlands Canada, or Sweden by the postwar baby boom The irregular patterns of aging for France and Sweden attest to the complex nature of the effects on age structure of changes in fertility, mortality, and migration, especially as a result of war and depression The actual magnitudes of the changes shown (as, for example the great increase in the index of intensity of aging for the United States between 1920–30 and 1930–40) are affected also by census errors in reporting and especially by

TABLE 5

RATIO OF RATE OF INCREASE OF POPULATION 65 YEARS OLD AND OVER TO RATE OF INCREASE OF POPULATION UNDER 65 YEARS FOR SIX SELECTED COUNTRIES BY DECADE 1900–1950 AND BY HALF CENTURIES 1850–1950

COUNTRY	RATIO OF RATES IN GIVEN DECADE					RATIO OF RATES IN GIVEN HALF CENTURY	
	1900–1910	1910–20	1920–30	1930–40	1940 50	1850–1900	1900–1950
France	2 2	5 1	1 5	23 2		6 1	9 3
United Kingdom	2 3	5 1	8 0	10 8	8 8	1 0	5 4
Sweden	1 1	0 9	4 3	1 6	2 1	2 7	1 8
United States	1 3	1 6	2 1	5 6	2 6	*	2 2
Canada	0 7	1 1	2 0	3 2	1 9	*	1 5
Netherlands	1 2	0 7	1 4	2 2	1 9	1 5	1 4

* Data not available

Among the four countries for which data are available for 1850–1900, France aged the most rapidly and England the least However, England increased her rate of aging the most between the two half century periods considered England s index of intensity of aging increased fivefold between the two half century periods while France's index went up 50 per cent Sweden s actually declined, and the Netherlands remained at about the same level

The index of intensity of aging by decades falls into reasonably regular patterns As a result of the postwar boom in births, aging declined in intensity between 1940 and 1950 in comparison with the experience of 1930–40 for each of the countries for which data are available, except Sweden In the United States, Canada, the Netherlands, and the United Kingdom the process of aging accelerated, decade by decade, until decelerated response variability in reporting age in relation to social security developments

D The Process of Aging

The age structure of a population, as has been indicated above, is the result of the interplay of fertility, mortality and migration To the lay person it would seem that decreased mortality must be the most important factor in the aging of a population Actually, as has been suggested above, this is not the case

Let us examine the effects on the age structure of a population of changes in death rates and birth rates and begin with the consideration of mortality

Crude death rates are shown as far as the data permit, for the nine selected countries in Table 6 from 1905 to 1909 It may be observed that all these countries have

consideration of fertility Five year average crude birth rates are shown in Table 8

It may be seen that the birth rate has fallen in each of the countries under consideration during the course of this century through the depression thirties, during which each of the nations experienced its low point in fertility The war period had irregular effects on the birth rate, reflecting differences in participation in the war The postwar period produced increases in fertility for all these nations, although of varying degrees and durations

Comparison of crude birth rates among these countries is like the *crude death rate*, affected by differences in the *age structure* of the population The data for controlling differences in age structure for international comparison are not too satisfactory and are, therefore, not presented here The point in presenting these crude birth rates at this juncture is merely to indicate that the birth rate as well as the death rate, has been declining in each of the nations under consideration

With both decreasing mortality and decreasing fertility under way, which has the greater effect on aging? It is possible to obtain an answer to this question by resorting to the use of one of the demographer's powerful tools of analysis, namely, the "stable-population" model

The "stable population" is the population which would result if, assuming a closed population, that is, no migration, an observed set of birth rates and death rates at each age continued to operate indefinitely It is called a "stable" population, even though it may increase or decrease, because both its age structure and its rate of change become fixed or stable By constructing stable populations for different combinations of birth and death rates, it is possible to determine how changes in fertility or mortality affect the age structure This has been done for our purposes by constructing stable populations for Sweden and for the United States for four combinations of birth and death rates, respectively For each country a set of high and low fertility rates was held constant, while high and low sets of mortality rates, respectively, were used with each set of fertility rates

For Sweden the "high" fertility rates used were those for the period 1948–52, the "low" fertility rates were those for 1933–37 The "high" mortality rates were for 1931–40 and the "low" for 1951–55 For the United States the high and low fertility rates were for 1950–54 and 1935–39, respectively, and the high and low mortality

TABLE 8

CRUDE BIRTH RATES FOR NINE SELECTED COUNTRIES 1905–54
(Five Year Averages)

Canada	‡	‡	25 2	21 5	22 2	20 3	26 5	26 8	27 8
Netherlands	30 0	28 1	26 7	23 4	21 7	20 3	21 8	25 9	22 1
Czechoslovakia	33 0	29 6	26 7	22 9	19 7	17 1	20 8	22 3	‡

* For the period 1910–14
† For West Germany from 1945 to 1954
‡ Data not available
§ For the period 1946–49

TABLE 7

EXPECTATION OF LIFE AT SPECIFIED AGES FOR NINE SELECTED COUNTRIES BY SEX, IN OR AROUND 1900, 1930, AND 1950

COUNTRY AND YEAR	LIFE EXPECTANCY FOR GIVEN SEX AND AGE							
	Male				Female			
	0	20	40	65	0	20	40	65
France								
1898–1903	45 31	41 03	26 65	10 46	48 69	43 59	29 10	11 47
1928–33	54 30	43 30	27 62	10 86	59 02	47 40	31 37	12 57
1950–51	63 60	48 40	30 40	11 90	69 30	53 40	35 00	14 40
England and Wales								
1901–10	48 53	43 01	26 96	10 80	52 38	45 77	29 37	11 99
1930–32	58 74	46 81	29 62	11 30	62 88	49 88	32 55	13 07
1951	65 80	49 10	30 50	11 20	70 90	53 50	34 70	13 80
Sweden								
1901–10	54 53	45 88	30 77	12 81	56 98	47 66	32 53	13 69
1931–35	63 22	49 44	32 50	13 15	65 33	50 55	33 54	13 71
1946–50	69 04	52 14	33 84	13 53	71 58	53 95	35 29	14 27
Germany								
1901–10	44 80	42 60	26 60	10 40	48 30	44 80	29 20	11 10
1932–34	59 86	48 16	30 83	11 87	62 81	49 84	32 33	12 60
1949–51†	*64 60*	*50 30*	*32 30*	*12 80*	*68 50*	*53 20*	*34 70*	*13 70*
United States								
1900–1902	47 88	38 38	27 65	11 50	50 70	39 92	29 08	12 22
1929–31	57 71	44 88	28 68	11 72	60 99	47 21	30 86	12 78
1949–51	65 47	48 92	30 79	12 74	70 96	53 73	35 06	14 95
Italy								
1901–11	42 24	43 27	28 23	10 74	44 83	43 69	29 18	10 81
1930–32	53 76	46 75	30 39	11 92	56 00	46 75	32 14	12 66
Canada								
1930–32	60 00	49 05	31 98	12 98	62 10	49 76	33 02	13 72
1950–52	66 33	50 76	32 45	13 31	70 83	54 41	35 63	14 97
Netherlands								
1900–1909	51 00	45 70	29 50	11 60	53 40	46 90	30 80	12 30
1931–40	65 50	50 80	32 80	12 80	67 20	51 50	33 30	13 30
1950–52	70 60	53 70	34 90	14 10	72 90	55 40	36 30	14 70
Czechoslovakia								
1929–32	51 92	45 29	28 96	11 32	55 18	47 40	30 98	12 06

* Source United Nations *Demographic Yearbooks*

† For West Germany

IV Composition of Population

A Population Pyramids

The age structure of the selected countries in about 1950, compared with about 1900 is shown in Figures 5–12 The figures portray the results of the processes and the data described above It is to be noted that, without exception, the 1950 age structure of the countries considered have larger older components and smaller younger components than they had in 1900 The discrepancies are greatest for France (Fig 11) and smallest for the Netherlands (Fig 8) The United States (Fig 10), as may be expected, lies between these nations in differences between its 1950 and 1900 age structure A close examination of these pyramids gives some indication of the role of both fertility and mortality in the aging of a population, for in each of these countries aging was the result both of a shrinking base (fertility decline) and of an expanding apex (mortality decline)

B Labor Force by Age

As a population ages so does its labor force or "economically active" members Of special interest in the consideration of aging

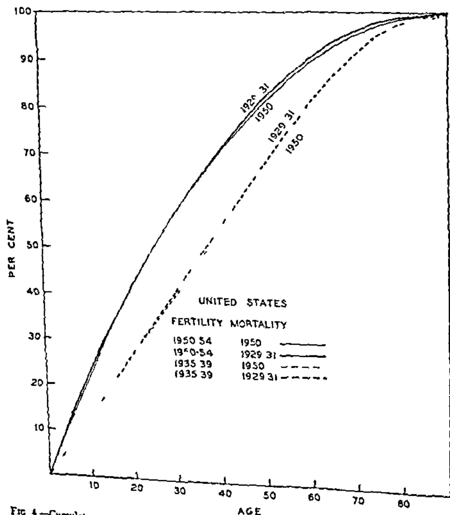


Fig 4 —Cumulative percentage distribution of stable population of the United States with average fertil... ...ven years.

rates were for 1929–31 and 1950, respectively The results of these calculations are shown in Figures 3 and 4

In each of these nations it is clear that variations in fertility have much more effect on age structure than do variations in mortality With the high sets of fertility, the age structure of the stable population remains approximately the same (compare the *solid and broken lines*), *whether high or low* patterns of death rates are used Likewise, with the low sets of birth rates, the age structure of the stable population remains about the same, whether the high or low sets of death rates are used (compare dash dot and dot lines) These findings are consistent with those of other studies and permit the following conclusion Fertility is more important than mortality in its effects on the age structure of a population under the conditions of "closure' assumed by the stable population model In the nations with the older populations, then, it is the declining birth rate more than the declining death *rate that has produced the observed aging* Thus it is now clear why France, with higher death rates than the Netherlands, nevertheless has an older population The explanation lies in the greater decline in the French than in the Dutch birth rates

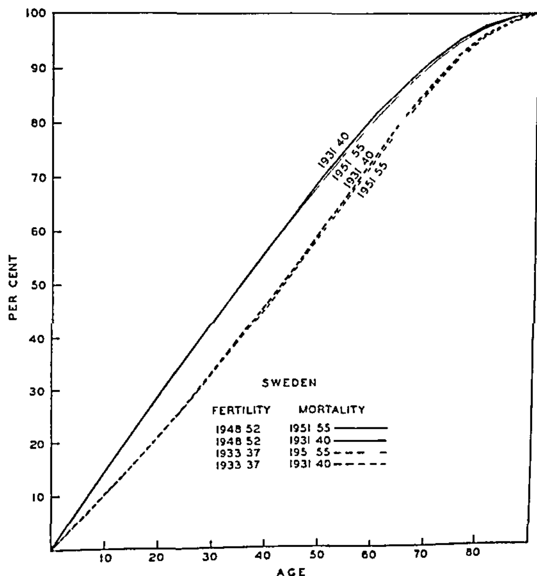


FIG 3 —Cumulative percentage distribution of stable population of Sweden with average fertility and levels in given years.

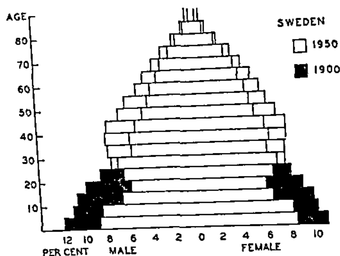


FIG 7—Population pyramid for Sweden 1900 and 1950

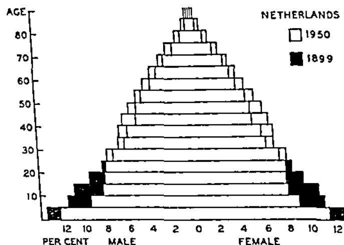


FIG 8—Population pyramid for the Netherlands 1899 and 1950

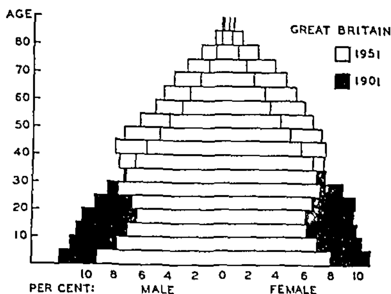


FIG 5 —Population pyramid for Great Britain, 1901 and 1951 (Data in Figs 5–12 from United Natio *The Aging of Populations and Its Economic and Social Implications* ["Population Studies," No 26 (N York United Nations, 1956)])

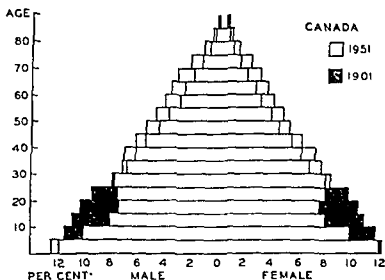


FIG 6 —Population pyramid for Canada, 1901 and 1951

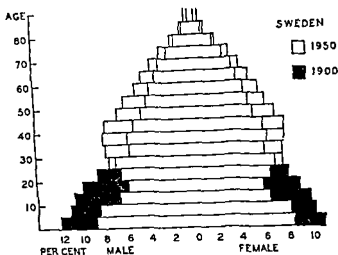


FIG 7—Population pyramid for Sweden, 1900 and 1950

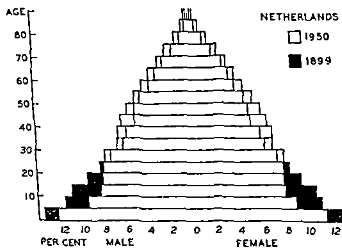


FIG 8—Population pyramid for the Netherlands, 1899 and 1950

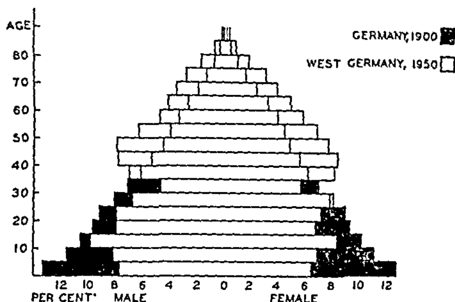


FIG 9 —Population pyramid for Germany, 1900, and West Germany, 1950

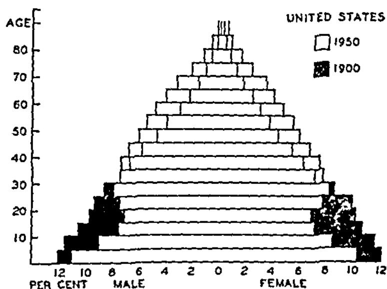


FIG 10 —Population pyramid for the United States, 1900 and 1950

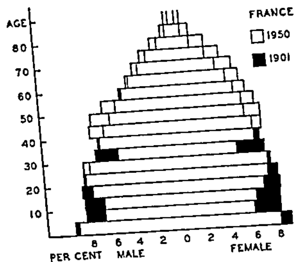


FIG 11 —Population pyramid for France 1901 and 1950

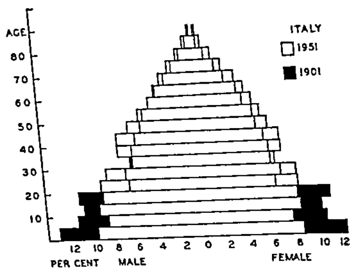


FIG 12 —Population pyramid for Italy, 1901 and 1951

in respect to labor-force activity are the labor-force-participation rates of older persons, on the one hand, and the proportion of the total labor force which is 65 years old and over, on the other. Each of these items is shown for males in Table 9. The labor-force data for females are not considered because they involve difficult problems of comparability arising from differences in national definitions and census practices.

Again it may be noted that France, among the seven nations for which data are presented, has both the highest proportion of her labor force in the older age category and the highest labor-force participation rate for older male workers In 1946, 7 6 cent of France's male workers were 65 years of age and over. In contrast, among these nations, less than 5 per cent of the workers in West Germany, the United Kingdom, and the Netherlands were 65 and over, and between 5 and 6 per cent of the workers in Canada, the United States, and Sweden Moreover, in France well over half of the males 65 years and older (54 4 per cent), were in the labor force In contrast, little more than a fourth of the male workers 65 and over in West Germany were economically active (26 8 per cent). (This relatively low percentage is partly the result of the fact that West Germany is more urban because of the split of Germany.) In the United Kingdom, the Netherlands, and Sweden about one-third of the older males were economically active; and in the United States and Canada about two fifths of the older males were in the labor force These differences reflect, of course, mainly differences in provision for pensions for older workers as well as differences in urban rural distribution of population As will be shown below for the United States, agricultural workers tend to remain economically active longer than non agricultural workers

TABLE 9

MALE LABOR FORCE PARTICIPATION RATES AND OLDER LABOR FORCE OF SEVEN SELECTED COUNTRIES AROUND 1950

COUNTRY AND YEAR OF CENSUS	MALE LABOR FORCE PARTICIPATION RATES				MALE LABOR FORCE 65 YEARS AND OVER AS PERCENTAGE OF TOTAL LABOR FORCE
	14 Years and Over	15–44 Years	45 64 Years	65 Years and Over	
France, 1946	85 5	92 0	89 0	54 4	7 6
United Kingdom, 1951†	87 9	95 8	95 4	32 0	4 4
Sweden, 1950	84 5	93 3	92 2	36 1	5 3
West Germany, 1950	83 0	93 6	89 6	26 8	3 8
United States, 1950‡	78 9	83 4	88 2	41 5	5 5
Canada, 1951§	82 4	89 3	90 7	39 5	5 1
Netherlands, 1947‖	85 1	88 4	93 5	35 6	4 0

* Source United Nations *Demographic Yearbook 1954*

† Based on a 1 per cent sample (does not include Northern Ireland)

‡ Based on a 20 per cent sample

§ Excludes Yukon and Northwestern territories

‖ The age groups are 14 39, 40–64 and 65 and over

Thus France, the most aged of the Western nations, has the largest population of older persons among her male workers and the largest proportion, by far, of males 65 and over who are economically active France's labor-force participation rate for older men is one-third above that for the next highest nation and twice that for the lowest of the nations considered These differences are in some measure the result of the fact that the data for France, 1946, are closer to the war-mobilization state than the

data for the other countries They may, however, also reflect social, cultural, and economic differences and also raise the question of whether France's older population is also a factor That is, it is possible that, with the increasing aging of a population, older persons may have to work because of the economic pressure of the increased burden of dependency represented by a high proportion of aged persons

V Summary and Concluding Observations

The "age" of a population is more complex and more difficult to determine than the age of a person Moreover, a population may grow younger or older over time, whereas a per

the age of a population at any given time Of these factors, a declining birth rate is, in general the most important in produc

The continuation of declining fertility with declining mortality, characteristic of the more economically advanced nations

decreases in fertility, have relatively young populations Intermediate between the "young" and "old" nations are the "mature" countries, those *now* undergoing industrialization

Among

the

th

ob

m

as

Fr

65 or older, has aged rapidly during the course of this century Between 1900 and 1950, persons 65 and over in France increased nine times as rapidly as those under 65 In 1950 there were about 18 persons 65 and over for each 100 persons of working age, 15–64, 49 older persons for each 100 of intermediate age, 45–64, and 54 older persons for each 100 children under 15 years of age All other things being equal, France's age structure tends, therefore, to decrease her product per head, retard the rate of promotion of her more active workers, and produce a relatively mature environment, *personal and physical, for her* children

The full personal, social, political, and economic consequences of a relatively aged population are not known Yet there is undoubtedly a connection between France's relatively high proportion of older persons and the fact that her older workers remain economically active in larger proportion than those in other countries The relatively large proportion of the French labor force which is 65 and over may further adversely affect her productivity Moreover, it is possible that France may have been adversely affected, both in the economic and the political realms, by the greater proportion, and possible great

France's economic and political difficulties in the pre and postwar periods Finally, it may be further con

of the children in France may conceivably have adverse effects on the vivacity, the adventuresomeness, the self-expression, the initiative, and the creativity of her youngsters.

The other Western nations, including the United States, are certainly faced with the prospect of continued aging This process will be relatively rapid if the birth rate continues its secular decline, as the postwar marriage and baby booms are dissipated In the United States, for example, the current recession has broken the postwar boom in marriages and is beginning to effect declines

in the birth rate Should the birth rate continue its downward trend, the population of the United States, the aging of which was slowed by relatively high postwar marriage and fertility rates, will continue to age at an accelerated rate Under conditions of declining fertility and mortality all the Western nations could, within a relatively short time, approximate the age structure of France With such an age structure they would, also, be subject, of course, to the economic, social, and political consequences of aging

The "mature" and "young" nations of the world, while they are also subject to aging as their mortality and their fertility decline, are not likely to approximate an age structure like France's for many decades The only factor which could change this outlook would be necessarily spectacular developments which would greatly reduce their birth rate at rates of decline greatly surpassing those of France and the other Western nations This, for the time being, does not seem a likely event

A final observation on national differences in aging seems in order The world political order today is characterized by three distinctive political groups, the "free world," of which the United States is the leader, the "Communist world," of which the U S S R is the leader, and the "neutral" or "uncommitted world," of which India is probably the key nation It is of some interest that this political division tends to coincide with the United Nations classification of nations by age That is, the free world is made up, in the main, of the relatively old countries, whereas the Communist world includes only "mature" and "young" countries, and the uncommitted countries are virtually all "young"

If youth means vigor and age debility, the Western and free nations may be handicapped in the intense competition—economic, social, political, and perhaps military—which seems to lie ahead But youth has not always triumphed over age, and age has many virtues and strengths not possessed by youth The relation of age to the political question which is posed, while exciting and portentous, is, in the present state of knowledge, not known In posing the political question, however, it perhaps makes more clear and also more dramatic the need to learn about the consequences of the aging of nations

REFERENCES AND BIBLIOGRAPHY

COALE, A J 1956 The effects of changes in mortality and fertility on age composition *Milbank Mem Fund Quart*, *34*, 79–114

DONAHUE, WILMA, and TIBBITTS, C (eds) 1957 The new frontiers of aging Ann Arbor University of Michigan Press

HAUSER, P M, and SHANAS, ETHEL 1952 Trends in the aging population *In* A I LANSING (ed), Cowdry s problems of ageing pp 965–82 3d ed Baltimore Williams & Wilkins Co

HAWLEY, A H 1959 Population composition *In* P M HAUSER and O D DUNCAN (eds), The study of population an inventory and appraisal, pp 361–82 Chicago University of Chicago Press

LORIMER, F 1951 Dynamics of age structure in a population with initially high fertility and mortality (Population Bull No 1) New York United Nations

NOTESTEIN, F 1954 Some demographic aspects of aging Proc Am Philosophical Soc., *98*, 38–45

SAUVY, A 1953 L'Europe et sa population Paris Les Éditions Internationales

——— 1954 Le vieillissement des populations et l allangement de la vie *Population*, *9*, 675–82

SHELDON, H D 1958 The older population of the United States New York John Wiley & Sons

TIBBITTS, C (ed) 1959 Aging and social health in the United States and Europe Ann Arbor Division of Gerontology University of Michigan

UNITED NATIONS DEPARTMENT OF ECONOMIC [illegible]

United Nations

——— 1955 Age and sex patterns of mortality ("Population Studies," No 22) New York United Nations

——— 1956 The aging of populations and its economic and social implications ("Population Studies," No 26) New York United Nations

——— 1958*a* The future growth of world population. ("Population Studies," No 28) New York United Nations

——— 1958*b* Recent trends in fertility in industrialized countries ("Population Studies," No 27) New York United Nations

UNITED NATIONS STATISTICAL OFFICE 1955–58 Demographic yearbooks New York United Nations

UNITED NATIONS WORLD POPULATION CONFERENCE 1955 Age structure and labor supply *In* Transactions of the World Population Conference New York United Nations

VALAORAS, V G 1950 Patterns of aging of human populations *In* Social and biological challenge of our aging population, pp 67–85 New York Columbia University Press

III

Employment and Retirement

SEYMOUR L. WOLFBEIN AND ERNEST W. BURGESS

One of the overriding and fundamental trends which has affected employment patterns in the United States, western Europe, and, in fact, virtually every industrialized nation in the world is represented by the changes which have occurred in man's span of working life during the twentieth century. A brief review of some of the forces which have impinged upon the length of working life, the social and economic context in which these changes have taken place, and the results they have generated provides a significant background to the gerontological evolution both here and abroad.

I. The Length of Working Life

The length of time a person spends as an economically active member of the population is a function of a number of forces, all of which are highly correlated with the social and economic progress of his country. He must, in the first place, survive to an age where it is feasible for him to make his first part time or full time entry into the labor force, and, of course, the length of time he spends thereafter as a worker also depends in a major way on how long he lives.

At the same time, however, custom, law, tradition, industry, and business practice also play pivotal roles in determining the length of a man's working life. To the extent that a country has compulsory school attendance laws or laws stipulating a minimum working age, the time of labor force entry may be extended further and further into a person's teens. Technological developments and advances in science may make it necessary for a person to get more education and training before becoming a worker, with the same results in terms of delay in labor market entry.

At the other end of the age scale, barriers or discrimination on the basis of age may cut off a person's working life. Social insurance systems and private pension plans also have a marked effect on what part of a person's older years are spent as a worker. All these major forces are, in a sense, summarized and reflected in what we call the "length of working life."

A. United States Experience

The experience in the United States can be summarized very briefly and will serve as our benchmark against which we can view the experience of other countries. In this country there has been a significant and substantial *increase* in the three primary forces which have played a vital role in shaping the social and economic trends which form the subject of this chapter as well as this volume: (*a*) life expectancy—the total span of our lives; (*b*) work life expectancy—the years we spend as economically active members of our society; and (*c*) the years spent outside the labor force—as youth getting education and training and as other persons in retirement. In Table 1, in a few figures, is the story for the United States.

The fact that all three forces—life, working life and non-working life—have increased simultaneously in the last 50-odd years represents the basic framework for the problems we are considering. Thus the increasing expectation of life is the primary generator of the 'older worker problem' to begin with. We have long passed the time, both here and abroad, where this problem referred to a comparatively small population group. In terms of sheer numbers as well as proportions of the total population of a country, we are dealing with a significant and substantial social, economic, and political force.

the labor market. In fact, in the United States the average American male makes his first full time entry into the labor force between his eighteenth and nineteenth year of life. At the turn of the century, more than one out of every five youths 10–15 years of age were already workers. This trend has had a number of overriding effects on the problems we are considering—including the increasing education and training of persons when young and the subsequent results in terms of their future working lives as well as the very impact on the older person as a manpower resource in the light of delayed entry by youth.

TABLE 1*

LIFE-EXPECTANCY, WORK LIFE EXPECTANCY AND YEARS OUTSIDE LABOR FORCE, BY SEX, UNITED STATES

Year	Men			Women		
	Life-Expectancy	Work Life-Expectancy	Years outside Labor Force	Life-Expectancy	Work-Life-Expectancy	Years outside Labor Force
1900	48.2	32.1	16.1	50.7	6.3	44.4
1940	61.2	38.3	22.9	65.9	12.1	53.8
1950	65.5	41.9	23.6	71.0	15.2	55.8
1955	66.5	42.0	24.5	72.9	18.2	54.7

* Source: S. L. Wolfbein, "The Length of Working Life," in *Proceedings of the Fourth Congress, International Association of Gerontology, Merano, Italy* (Fidenza, Italy: Tipografia Tito Mattioli, 1959), 3: 153–64.

Again, increasing life-expectancy, combined with the concentration of exits from the labor force during the sixth decade of life, has operated to increase the period of time spent in retirement. In the United States the average number of years spent in retirement by men more than doubled between 1900 and 1955. It is this increase in the span of life spent in retirement that brings to the fore the major questions of social insurance, income adequacy, housing and many other related problems.

Yet the increasing amount of time spent in retirement has been matched by an equally important development at the other end of the age scale: there has been a marked increase in the age at which young persons make their first full time entry into

It will be noted from Table 1 that part of our increased longevity has gone into an increase in the number of years spent in the labor force—into the vital span of our working lives—and part into an increase in the years spent outside the labor force. This points to a tremendously important fact which has prevailed here as well as in many other nations of the world: despite the substantial delay in entry into the work force by young people and the earlier exits by older persons, we actually put in many more years of work than did our counterparts 50 years ago. And paradoxical as it may seem, despite these added years of labor force activity, we spend more of our lives in retirement than did our 1900 counterparts. The answer to this

seeming paradox is, of course, the added years of total life we have today

The fact is that men today put in about a decade more of work during their lives than they did under 1900 conditions, but the data show that men really do not spend a much smaller proportion of their lives outside the labor force than they did back at the turn of the century The longer life afforded them permits more time as workers and more time for education at one end of the age scale and more retirement at the other

Much the same situation is true among women, who have experienced a tremendous increase in labor force activity since the turn of the century—the average number of years of working life among women has tripled between 1900 and 1955 Yet, as Table 1 shows, the 22 years of additional life expectancy available to women in this country since the turn of the century has been divided almost equally between labor force activity and non labor force activity 12 more years for working life, 10 more for education and training, marriage, and motherhood—and, of course, retirement.

To summarize briefly, the interrelationships among life, working life, and non working life set the basic structure of the problems of employment and retirement we are considering In this country the trends among the three have resulted in a longer life, with more older persons in general and more older workers in particular, a longer span of working life yielding a significantly higher manpower potential generated by the population, and a longer period spent outside the labor force at both ends of the age scale, yielding particularly significant increases in time spent in education and training to begin with and in time spent in retirement

TABLE 2*

TRENDS IN LIFE AND WORKING LIFE SELECTED COUNTRIES
(In Years)

Country	Time Period	Life Expectancy	Work Life-Expectancy	Non Work Life-Expectancy
Sweden	1816–40	41 47	25 59	15 88
	1931–35	64 24	38 09	26 15
France	1864	39 85	23 93	15 92
	1933–38	58 71	35 66	23 05
Germany	1871–80	36 97	22 74	14 18
	1932 34	61 29	37 04	24 25
Switzerland	1876–80	41 86	25 91	15 95
	1933–37	62 59	38 06	24 53
Italy	1881 90	35 40	26 40	14 00
	1930–32	54 85	32 92	21 93
Australia	1881–90	48 97	29 80	19 17
	1932–34	65 26	39 00	26 26
United States (white)	1900–1902	49 61	30 11	19 50
	1939–41	64 99	39 26	25 71

* Source G Mortara Durée de la vie économiquement active suivant la mortalité *Bulletin of the International Statistical Institute* Part IV *Demography and Labour Statistics* 33 (1951) 147 74

B Experience Abroad

The experience we have described for the United States has characterized societies of

the Western world with practically no exceptions The particular experience of a specific country varies, of course, with its social and economic history, its mores and traditions, the impact of war and peace, etc. But the primary evolutionary forces which have impinged upon life and working life are essentially the same in Western society

The substantial amount of materials developed by Giorgio Mortara (1951), a student of these phenomena for more than a half-century, gives rather vivid testimony on the similarity of these trends among the various nations of the world Table 2 is illustrative

Considering the great difference in time periods involved, as well as the substantial variations in the industrial and economic history among the various nations, the similarity in trend shown by Mortara's data is quite significant In each of the countries, expectancies of life, of work life, and of non work life all went up, as they did in the United States The duration of life spent outside the labor force rose considerably, but so did the span of working life under conditions of increasing longevity

Reflecting upon his studies of the data for forty countries, Mortara makes some points of considerable interest not only to the subject of this chapter but to some of the others in this volume He says (translating freely from the French)

> mc
> ing
> thi
>
> m. a whole group of improvements in conditions of life which have favorably affected the work capacity of individuals and which reflects itself in the reduction in the frequency and duration of illness and in invalidism caused by ill health.
>
> Thus we can say that a sexagenarian living in a country or in an age of low mortality has a much superior capacity for work than he would would have in a country or in an age of high mortality It would appear to be absurd to attribute the same upper age limit to working life to an American as to a Chinese or to a Swede living today and one of 200 years ago
>
> In fact the decline in mortality is accompanied by a moderate increase in the upper age limit of economically active life This increase, without doubt, is more than sufficient to compensate for any economic disadvantage resulting from a slight increase in the ratio between the average duration of all periods of economic inactivity and the economically active period, which apparently accompanied a decline in mortality [1951, pp 173–74]

More recently, a number of countries have been studying some of these phenomena through the use of standard actuarial techniques, resulting in a series of tables

TABLE 3*

EXPECTANCY OF LIFE AND WORKING LIFE AT BIRTH FOR MEN IN FRANCE

Year	Life-Expectancy	Work Life-Expectancy	Years outside Labor Force
1906	46 9	32 3	14 6
1936	55 9	37 0	18 9
1946	61 6	41 0	20 6

* Source P Depoid "Tables française concernant la population masculine (1906–1946)" *Bulletin of the International Statistical Institute* Part IV *Demography and Labour Statistics* 33 (1951) 131–46

... one country to another, reinforce our general conclusions, as the following brief illustrations show

P Depoid (1951) constructed a series of tables of working life for France, from which we abstract summary figures (Table 3) comparable to those we presented above for the United States

The trends during the first half of this century in France parallel ours about as closely as could possibly be expected As was true in the United States, all three of the forces being studied increased in France The pattern of change in France has also been very similar to ours There, too, a substantial increase in age of entry by the young and a significant decrease in

age of exit from the work force by the older person have occurred. But, as Depoid (1951) points out, "despite the reduction in age of entry and earlier retirement, work life expectancy has continued to increase under the important influence of declining mortality" (p. 140). This was exactly our comment on the trend in the last 50 years in this country.

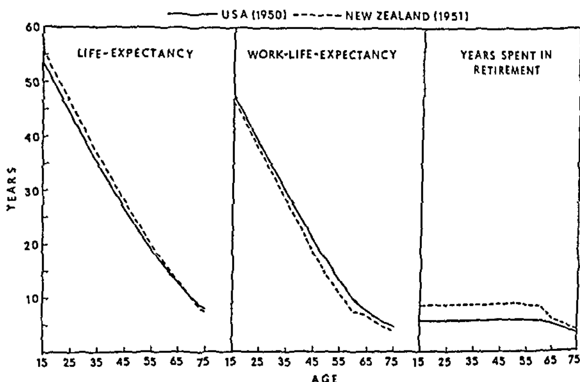
Moving across to the other side of the world, we find a recent (1951) table of working life constructed by the government of New Zealand (1955) exactly comparable to the 1950 table for the United States. The three important factors being examined in this section are presented for both the United States and New Zealand in Chart I. Considering the many differences between the two countries (the New Zealand table, incidentally, includes the Maoris), the similarities in both levels and structural patterns by age for the two countries are quite striking (New Zealand 1955).

II. The Older Person as a Worker

With increasing duration of life and working life, the older person has become a more and more significant factor in the manpower resources of his country. Table 4 and Chart II describe one dimension of the role of the older person as a worker, showing the extent to which men and women in their sixth decade of life continue as active participants in the labor force in western Europe and some of the British commonwealths. Although pension and retirement systems begin to operate in many of these countries for persons in their early sixties, worker rates are relatively quite high for men between 60 and 64 years of age. For western Europe proper, the lowest labor market participation rates for men 60–64 years of age prevail in Austria, where

CHART I

Life- and Work Life Expectancy and Years Spent in Retirement, Males, by Age, New Zealand and the United States



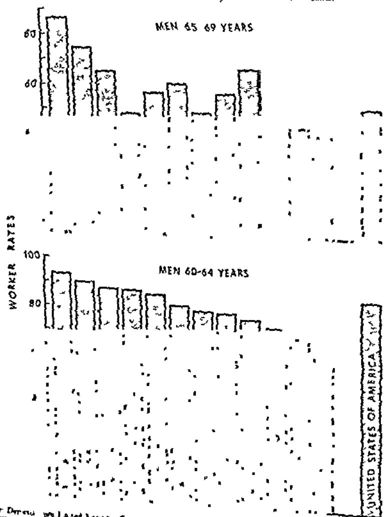
Source: Derived from New Zealand *Table of Working Life 1951 Male Population (Including Maoris)* (Wellington, N.Z. Census and Statistics Department 1955)

seven of every ten men in this age group are still active in the labor force Worker rates for these men reach close to, and even hit, the 90 per cent mark in such nations as Norway, Switzerland, Denmark, and the United Kingdom Similarly, for men in their later sixties—more than two of every five are still in the labor force in Austria, and the proportion goes up to a high of 75 per cent in Norway

Women have become an important factor in the worker resources of all countries, although the more striking trends here have affected those in the age groups below 60 Still, the data show that labor market participation among older women is relatively high, too—and, of course, much higher than a generation ago Social and economic differences make for extremes, as shown in Table 4, indicating, for example, a labor-market participation rate of about 14 per cent for women 60-64 years of age in the United Kingdom and 40 per cent in France and Finland But, for the rest of western Europe, worker rates for these women vary within a comparatively small range of one-

CHART II

WORKER RATES FOR OLDER MEN, SELECTED COUNTRIES



Source Derived from United Nations *Demographic Yearbook* 1956 Percentage for Finland of men 65–69 years was based on high proportion engaged in agriculture and no retirement requirement for eligibility for pension.

fifth to one-quarter. Similarly, for women 65–69 years of age, anywhere between 10 and 20 per cent are still in the active labor force.

In addition to technical and conceptual differences in enumeration, the economic background of the country and the economic opportunities for older persons go a long way toward explaining the differences as well as the similarities in worker rates shown in Table 4. For example, older people tend to stay in the labor force longer in agriculture than, say, industry. Thus at least part of the differences in worker rates between the United Kingdom and Sweden and Switzerland, for example, can be explained by the fact that only 6 per cent of the male labor force in the former nation is employed in agricultural and related pursuits as against 45 per cent for the latter two countries.

The occupational and industrial pursuits of older people are of great interest to us here, however, above and beyond their meaningfulness in explaining differential worker rates. They are of substantive interest in themselves as indicators of the kinds of jobs older persons hold and their relative importance in their country's economy. While these kinds of data are not generally available on a current comparable basis, Table 5 presents some information which is pertinent and again underscores some of the basic similarities and differences in the phenomena we are examining

TABLE 4*

PERCENTAGE WORKER RATES FOR OLDER MEN AND WOMEN, SELECTED COUNTRIES

Country	Worker Rates					
	Men			Women		
	Total	60–64 Years	65–69 Years	Total	60–64 Years	65–69 Years
United Kingdom (1951)	87 9	87 8	48 7	34 5	14 4	9 0
Canada (1951)	82 3	81 4	60 1	23 7	12 4	8 5
Australia (1947)	65 3	79 9	49 7	19 0	10 4	6 9
New Zealand (1951)	58 4	63 9	40 0	17 8	8 9	5 2
[illegible] (1950)	64 5	85 9	57 5	32 2	23 6	13 0
[illegible]	86 6	90 0	75 4	26 9	22 5	17 8
[illegible]	65 2	79 7	56 4	23 2	18 9	11 8
[illegible]	87 6	86 6	NA†	52 4	42 0	NA
France (1946)	85 5	76 3	66 5	46 2	40 2	31 3
West Germany (1950)	63 2	73 0	NA	31 4	21 2	NA
Austria (1951)	63 9	69 9	43 6	35 1	25 9	19 1
Switzerland (1950)	66 7	87 9	65 9	26 2	23 8	17 3
United States (1950)	78 9	79 4	59 8	29 0	20 5	12 8

* Source United Nations, *Demographic Yearbook, 1956*
† NA = Not available

Table 5 compares the occupational distribution of older males in the United States with the United Kingdom and Denmark, the latter two countries exhibiting some marked differences in economic base, as already indicated In the United States about 30 per cent of these workers are in the professional, managerial, clerical, and sales categories—all in what is generally called the "white-collar group" While many of the jobs in this group are routine, a substantial proportion are in the higher ranks of the occupational hierarchy, both

in status and in income Interestingly enough, the United Kingdom and Denmark also have a high proportion of their older men in these occupations although in these two countries the proportion is closer to *25 than to 30 per cent Both European* countries also have lower proportions in the managerial, administrative, and clerical groups and higher proportions in the sales categories than the United States

The reader can note the other major dimensions of the occupational structure among older persons in these countries by scanning the remaining data in Table 5 Of particular interest are the differences in the importance of agriculture the major role played by industrial and transport work and the relative importance of the service trades in the United Kingdom. It is noteworthy that about 40 per cent of the men 55–64 years at work are in industrial and transport occupations and that from one-quarter to one third of the men 65 years of age and over are similarly engaged

This leads us to examine another dimension of the occupational structure which prevails among older persons To what extent do the jobs older persons hold differ from those held by their younger counterparts? For this comparison we calculated an occupational distribution similar to that presented in Table 5 for men in the age group 35–44 years in which career development has had some chance to develop and in which the characteristic "problems of the older worker" are not yet as exacerbated (Table 6)

TABLE 5*

PERCENTAGE OCCUPATIONAL DISTRIBUTION OF OLDER MALE WORKERS SELECTED COUNTRIES

Occupation	United States		United Kingdom		Denmark	
	55–64 Years	65 Years and Over	55–64 Years	65 Years and Over	55–64 Years	65 Years and Over
Total	100	100	100	100	100	100
Professional and related workers	5	6	4	5	5	5
Managerial administrative and clerical workers	20	17	10	8	12	12
Sales workers	5	6	9	13	7	8
Farming fishing and related workers	19	28	8	13	29	35
Industrial workers (craftsmen production process workers and laborers)	37	24	30	27	36	33
Transport workers	3	2	10	5	7	4
Service	5	11	13	14	3	3
All other†	6	6	16	15	1	

* Source United Nations *Demographic Yearbook 1956*

† Includes workers whose occupation was not classifiable elsewhere (This amounted to almost 10 per cent in the United Kingdom.)

TABLE 6*

PERCENTAGE OCCUPATIONAL DISTRIBUTION OF MEN 35–44 YEARS OF AGE

Country	Total	White Collar	Farming	Industrial and Transport	Service	All Other†
United States	100	32	13	45	5	5
United Kingdom	100	24	7	46	9	14
Denmark	100	23	26	47	3	3

* Source Calculated from United Nations, *Demographic Yearbook 1956*

† Includes not elsewhere classified.

fifth to one-quarter Similarly, for women 65–69 years of age, anywhere between 10 and 20 per cent are still in the active labor force

In addition to technical and conceptual differences in enumeration, the economic background of the country and the economic opportunities for older persons go a long way toward explaining the differences as well as the similarities in worker rates shown in Table 4 For example, older people tend to stay in the labor force longer in agriculture than, say, industry Thus at least part of the differences in worker rates between the United Kingdom and Sweden and Switzerland, for example, can be explained by the fact that only 6 per cent of the male labor force in the former nation is employed in agricultural and related pursuits as against 45 per cent for the latter two countries

The occupational and industrial pursuits of older people are of great interest to us here, however, above and beyond their meaningfulness in explaining differential worker rates They are of substantive interest in themselves as indicators of the kinds of jobs older persons hold and their relative importance in their country s economy While these kinds of data are not generally available on a current comparable basis, Table 5 presents some information which is pertinent and again underscores some of the basic similarities and differences in the phenomena we are examining

TABLE 4*

PERCENTAGE WORKER RATES FOR OLDER MEN AND WOMEN SELECTED COUNTRIES

Country	Worker Rates					
	Men			Women		
	Total	60–64 Years	65 69 Years	Total	60–64 Years	65–69 Years
United Kingdom (1951)	87 9	87 8	48 7	34 5	14 4	9 0
Canada (1951)	82 3	81 4	60 1	23 7	12 4	8 5
Australia (1947)	65 3	79 9	49 7	19 0	10 4	6 9
New Zealand (1951)	58 4	63 9	40 0	17 8	8 9	5 2
[illegible]	64 5	85 9	57 5	32 2	23 6	13 0
[illegible]	86 6	90 0	75 4	26 9	22 5	17 8
[illegible]	65 2	79 7	56 4	23 2	18 9	11 8
[illegible]	87 6	86 6	NA†	52 4	42 0	NA
France (1946)	85 5	76 3	66 5	46 2	40 2	31 3
West Germany (1950)	63 2	73 0	NA	31 4	21 2	NA
Austria (1951)	63 9	69 9	43 6	35 1	25 9	19 1
Switzerland (1950)	66 7	87 9	65 9	26 2	23 8	17 3
United States (1950)	78 9	79 4	59 8	29 0	20 5	12 8

* Source United Nations *Demographic Yearbook 1956*
† NA = Not available

Table 5 compares the occupational distribution of older males in the United States with the United Kingdom and Denmark the latter two countries exhibiting some marked differences in economic base, as already indicated In the United States about 30 per cent of these workers are in the professional, managerial, clerical and sales categories—all in what is generally called the 'white-collar group' While many of the jobs in this group are routine, a substantial proportion are in the higher ranks of the occupational hierarchy, both

the United Kingdom in each of the countries the proportion engaged as employers or self-employed workers actually exceeds the wage and salary component in the 65 and-over age group The United States and the United Kingdom are similar in their exceptions because of the relatively smaller importance of agriculture in their respective economies in terms of numbers employed

The importance of self-employment as an area of labor market participation for the older person is often viewed against the apparent trend in this country and abroad toward the diminishing role of this kind of employment and the increasing trend—numerically and relatively—toward wage and salary jobs Does this point toward a gradual decline in employment opportunities for the older person?

This of course is a complex question and cannot be answered solely in terms of changing occupational trends But even within the confines of these trends there is at least one contraindicating factor At the same time that wage and salary employment has overtaken and exceeded self employment we have had another important development the growing trend toward white-collar jobs In this big area as we have shown the older worker has held his own—it is an area in fact where the older worker may be least disadvantaged (to put it negatively) or may have some substantial work advantages (to put it positively)

These reflections lead us to view the older person as a worker from another perspective So far we have considered the extent to which older persons participate in the labor force and the kinds of employment they follow To put it technically we took some specific age-sex group examined its labor market participation rate and its occupational distribution and made comparisons with other age-sex groups

It is also pertinent to put our inquiry this way How important is the older worker in the over all labor force picture of his country? For example for what part of his nation s labor force does the older worker account? How much of the employment in a given occupation is filled by older workers?

The available data reveal that men 55 years of age and over account for the proportions shown in Table 8 of the total male labor force for selected countries in western Europe Thus men 55 years and over account for anywhere from 14 to 19 per cent of their countries' male workers This is significant not only as a current indicator but also in terms of historical perspective since it was not many decades ago that the average male did not even survive to this age level

TABLE 8*

PERCENTAGE OF MALE LABOR FORCE 55 YEARS AND OVER SELECTED COUNTRIES

Country	Per Cent
France	14
West Germany	15
Finland	15
Denmark	17
United Kingdom	17
Sweden	18
Switzerland	19
United States	18

* Source United Nations *Demographic Yearbook 1956*

Similar calculations can also be made for a few countries on an occupational basis Table 9 for example shows the relative importance of the male worker 55 and over to the various occupational groups in the United Kingdom and Denmark and in comparisons with the United States Here again the figures can speak for themselves. Apparently the older worker plays an important numerical role in most occupational groups In many of them he actually accounts for from one out of five to one out of every four male workers in the field

This leaves us now with one last item in our general review of the older worker in the labor force—his role in the future A good deal of work has been done both here and abroad in projecting into the

Our point of comparison is now not only among countries but among age groups within each of the three countries (cf Table 5) It is highly significant to note that the proportions engaged as white collar workers (professional, managerial, and sales) are about the same for each age group In the United Kingdom, for example, 24 per cent of the men 35–44 years of age were occupied in this category, the corresponding percentages were 23 for men 55–64 and 26 for men 65 and over In Denmark the percentages were 23, 24, and 25, in the United States they were 32, 30, and 29

The major differences occur in the almost classic examples of farming and blue collar (industrial and transport) work In each country the proportion engaged in farming and related occupations goes up with age, while the proportion engaged in blue-collar work *does the opposite* (*i e*, goes down with increasing age) In the United States and the United Kingdom the proportion of men 65 and over in farming is about double that for the age group 35–44, in Denmark, a more agrarian economy, the rate for the older worker is about half again as large as for the men 35–44 years On the other hand, the proportion engaged in industry and transport is significantly higher in each country for men 35–44 than for men 65 and over Thus generally speaking, the farm and factory represent the illustrations, par excellence of the contrasting areas of economic opportunity for the older worker—both here and abroad

One other set of data illustrates and reinforces the points made up to now Information is available for this country and a number of western European nations on what proportion of workers (by age) are employed as wage or salary personnel, on the one hand, and as working for themselves or as employers of labor, on the other hand (Table 7)

In every one of the countries the proportion of men engaged as wage or salary workers is, of course, much higher than that engaged as employers or self-employed workers However, in each of them the proportion working in their own businesses goes up with age and is highest for those 65 years of age and over In fact with the exception of the United States and

TABLE 7*

PERCENTAGE OF MALE WORKERS ENGAGED AS WAGE AND SALARY WORKERS OR EMPLOYERS AND SELF EMPLOYED, BY AGE SELECTED COUNTRIES†

Country	All Male Workers		Age 55 64		Age 65 and Over	
	Wage and Salary Workers	Employers and Self employed Workers	Wage and Salary Workers	Employers and Self employed Workers	Wage and Salary Workers	Employers and Self employed Workers
United Kingdom	89	8	84	12	72	21
France	68	32	50	50	42	58
West Germany	77	18	66	33	29	69
Belgium	72	23	63	36	30	68
Denmark	71	29	56	44	42	58
Sweden	78	23	63	35	42	57
Netherlands	69	23	62‡	37‡	36	60
Switzerland	71	23	64	34	42	52
United States	78	21	70	29	59	40

* Source United Nations *Demographic Yearbook 1956*

† Where percentage adds to less than 100 remainder are either unpaid family workers or unclassifiable

‡ *Age 50–64*

crease of 850 000 in the labor force be tween 1954 and 1964 Of these 580 000 or 68 per cent will be persons 45 years of age and over In other words about two of every three additional workers during the decade would come from the 45 and over age group

As can be seen the British have also prepared projections for 1979 (a quarter of a century beyond the 1954 base period) and these show an even stronger picture in terms of the role of the older worker Over the 25 years 800 000 of the 1 000 000 projected labor force increase was ex pected to be supplied by persons 45 years and older In fact a full 400 000 are ex pected to be supplied just by men 65 and over and women 60 and over

The Organization for European Econom ic Co-operation has brought together pro- jections of the population of working age for the period 1951–71 for a number of western European countries Abstracting from the details we have the data given in Table 11

It should be remembered that we are dealing with the population of working age (generally men 15–64 and women 15–59) rather than with actual workers However only a rad cal shift in rates of labor market part cipation could change the conclusion that the labor force is and will grow older and that older persons will be a higher pro- portion of the labor force of most western European countries Only in Germany and Austria is there a marked shift to be ex pected the other way among males—and th s is because the older males in 1971 will represent an age cohort affected by the severe casualties of World War II

In summary then the employment and labor force p cture for the present and the more or less immediate future is much the same for the Western world and the United States. The span of man s working life has kept pace with the significant increases in his total life-span generating substantial increases in his nation s manpower poten tial and making the older person a prime resource in the over-all labor force and the occupational and industrial complex of his country

III The Older Worker and Retirement

At present there are two major ways of looking at retirement one negative and the other positive The negative conception of retirement is that of the giving up of gain ful employment The positive conception of retirement is that of a new way of life The negative conception appears to dominate much if not most of present day thinking

TABLE 11*

PERCENTAGE OF POPULATION OF WORKING AGE 45 YEARS AND OLDER BY SEX SELECTED COUNTRIES 1951 71

Country	Male		Female	
	1951	1971	1951	1971
United Kingdom	34	38	32	33
Belgium	36	37	33	32
Netherlands	30	31	27	28
Luxembourg	33	38	30	34
West Germany	36	32	32	33
Denmark	33	35	29	31
Norway	32	38	36	33
Sweden	34	40	30	34
France	34	33	33	29
Italy	28	33	26	30
Switzerland	34	36	31	32
Austria	38	33	34	33

about retirement at least in the sense that the greater good is for a person to con tinue to be gainfully employed as long as possible

It is pertinent then to examine retire- ment from this standpoint and to speculate upon the long time prospects of the rela tive place of work and retirement in the life and thinking of older persons The at tempt will be made to find tentative an swers to the following question (1) What is the long time trend in retirement? (2) What are the factors at present making for retirement? (3) What steps are being

future, not only in terms of anticipated changes in the manpower supply, but also in relation to future pension costs and other items.

What part of a nation's future labor force can be expected to be composed of older workers depends on a variety of social, demographic, and economic factors. The configuration of a country's population profile obviously will be a prime force. The existence of employment opportunity (or, oppositely, substantial unemployment) also plays a part. Important, too, are such questions as to whether older men will continue to display the long-term trend toward lower labor-market participation rates, especially after age 65, and whether women will continue their trend toward higher labor-market participation in their forties and fifties.

In the United States detailed labor-force projections have been made by age and sex (Wolfbein, 1959). Without going into the details, these projections show a ten-million labor-force increase between 1955 and 1965. One of every two of these additional workers will be 45 years of age and over.

In the United Kingdom detailed projections have also been made for almost exactly the same period of time—1954–64 (Great Britain, Committee on the Economic and Financial Problems of the Provision for Old Age, 1954). Unlike the United States, however, where the projections assumed continued drops in worker rates among men 65 and over and continued increases in worker rates among older women, the projections in the United Kingdom assumed the same age-sex labor-market participation rates in 1964 as prevailed in 1954. Nevertheless, the United Kingdom story also points to the increasing role of the older worker (Table 10).

These projections look toward an in-

TABLE 9*

PERCENTAGE DISTRIBUTION OF MALES BY OCCUPATIONAL GROUP UNITED KINGDOM, DENMARK, AND THE UNITED STATES

Occupational Group	Men in Each Occupation 55 Years of Age and Over		
	United Kingdom	Denmark	United States
Professional and related workers	15	19	15
Managerial, administrative, and clerical	19	21	20
Sales	20	17	15
Farming, fishing, and related workers	22	19	24
Industrial workers	*15*	*16*	*16*
Transport workers	16	14	8
Service workers	26	16	25

* Source: Calculated from United Nations, *Demographic Yearbook 1956*

TABLE 10*

ESTIMATED WORKING POPULATION OF GREAT BRITAIN

(In Millions)

Age Group	1954	1964	1979
15–44	15 01	15 28	15 29
Men 45–64, Women 45–59	7 23	7 70	7 63
Men 64 and over, Women 60 and over	1 07	1 18	1 47
Total	23 31	24 16	24 39

crease of 850,000 in the labor force between 1954 and 1964 Of these, 580,000, or 68 per cent, will be persons 45 years of age and over In other words, about two of every three additional workers during the decade would come from the 45 and over age group

As can be seen, the British have also prepared projections for 1979 (a quarter of a century beyond the 1954 base period), and these show an even stronger picture in terms of the role of the older worker Over the 25 years, 800,000 of the 1,000,000 projected labor force increase was expected to be supplied by persons 45 years and older In fact, a full 400,000 are expected to be supplied just by men 65 and over and women 60 and over

The Organization for European Economic Co-operation has brought together projections of the population of working age for the period 1951–71 for a number of western European countries Abstracting from the details, we have the data given in Table 11

It should be remembered that we are dealing with the population of working age (generally men 15–64 and women 15–59) rather than with actual workers However, only a radical shift in rates of labor market participation could change the conclusion that the labor force is and will grow older and that older persons will be a higher proportion of the labor force of most western European countries Only in Germany and Austria is there a marked shift to be expected the other way among males—and this is because the older males in 1971 will represent an age cohort affected by the severe casualties of World War II

In summary, then, the employment and labor force picture for the present and the more or less immediate future is much the same for the Western world and the United States. The span of man's working life has kept pace with the significant increases in his total life-span, generating substantial increases in his nation's manpower potential and making the older person a prime resource in the over all labor force and the occupational and industrial complex of his country.

III The Older Worker and Retirement

At present there are two major ways of looking at retirement, one negative and the other positive The negative conception of retirement is that of the giving up of gainful employment. The positive conception of retirement is that of a new way of life The negative conception appears to dominate much if not most of present-day thinking about retirement, at least in the sense that the greater good is for a person to continue to be gainfully employed as long as possible

TABLE 11*

Percentage of Population of Working Age 45 Years and Older by Sex, Selected Countries, 1951–71

Country	Male		Female	
	1951	1971	1951	1971
United Kingdom	34	38	32	33
Belgium	36	37	33	32
Netherlands	30	31	27	28
Luxembourg	33	38	30	34
West Germany	36	32	32	33
Denmark	33	35	29	31
Norway	32	38	36	33
Sweden	34	40	30	34
France	34	33	33	29
Italy	28	33	26	30
Switzerland	34	36	31	32
Austria	38	33	34	33

* Source Calculated from data in Organization for European Economic Co-operation, *Demographic Trends in Western Europe A Report by the Manpower Committee* (Paris Organization for European Economic Co-operation, 1956) Table VIA, pp 25–28

It is pertinent, then, to examine retirement from this standpoint and to speculate upon the long time prospects of the relative place of work and retirement in the life and thinking of older persons. The attempt will be made to find tentative answers to the following question (1) What is the long time trend in retirement? (2) What are the factors, at present, making for retirement? (3) What steps are being

future, not only in terms of anticipated changes in the manpower supply, but also in relation to future pension costs and other items.

What part of a nation's future labor force can be expected to be composed of older workers depends on a variety of social, demographic, and economic factors. The configuration of a country's population profile obviously will be a prime force. The existence of employment opportunity (or, oppositely, substantial unemployment) also plays a part. Important, too, are such questions as to whether older men will continue to display the long-term trend toward lower labor-market participation rates, especially after age 65, and whether women will continue their trend toward higher labor-market participation in their forties and fifties.

In the United States detailed labor-force projections have been made by age and sex (Wolfbein, 1959). Without going into the details, these projections show a ten-million labor-force increase between 1955 and 1965. One of every two of these additional workers will be 45 years of age and over.

In the United Kingdom detailed projections have also been made for almost exactly the same period of time—1954–64 (Great Britain, Committee on the Economic and Financial Problems of the Provision for Old Age, 1954). Unlike the United States, however, where the projections assumed continued drops in worker rates among men 65 and over and continued increases in worker rates among older women, the projections in the United Kingdom assumed the same age-sex labor-market participation rates in 1964 as prevailed in 1954. Nevertheless, the United Kingdom story also points to the increasing role of the older worker (Table 10)

These projections look toward an in-

TABLE 9*

PERCENTAGE DISTRIBUTION OF MALES BY OCCUPATIONAL GROUP UNITED KINGDOM, DENMARK, AND THE UNITED STATES

Occupational Group	Men in Each Occupation 55 Years of Age and Over		
	United Kingdom	Denmark	United States
Professional and related workers	15	19	15
Managerial, administrative, and clerical	19	21	20
Sales	20	17	15
Farming, fishing, and related workers	22	19	24
Industrial workers	15	16	16
Transport workers	16	14	8
Service workers	26	16	25

* Source Calculated from United Nations, *Demographic Yearbook 1956*

TABLE 10*

ESTIMATED WORKING POPULATION OF GREAT BRITAIN (In Millions)

Age Group	1954	1964	1979
15–44	15.01	15.28	15.29
Men 45–64, Women 45–59	7.23	7.70	7.63
Men 64 and over, Women 60 and over	1.07	1.18	1.47
Total .	23.31	24.16	24.39

* Source Great Britain, Committee on the Economic and Financial Problems of the Provision for Old Age, *Report* (Cmd. 9333) (London H.M. Stationery Office, 1954))

that there were no empirical data to support his theoretical analysis Results of a recent American study provides inferential evidence (Burgess and Thornbury, 1960) A comparison is made of the replies of 1130 older employees 55–64 years of age to two statements "If I can, I want to work full time after I am 65 and "After I am 65 I want to work part time to earn up to $1200 a year allowed by social security"

TABLE 13*

COMPARISON BETWEEN GREAT BRITAIN AND BIRMINGHAM IN THE EMPLOYMENT OF MALES 60–69

Age	Great Britain (1)	Birmingham (2)	Percentage Higher in Birmingham (2−1)
60	91 4	94 8	3 4
61	89 1	93 6	3 5
62	89 4	92 3	2 9
63	85 7	90 7	5 0
64	82 9	88 3	5 4
65	58 4	69 9	11 5
66	50 7	75 0	24 3
67	46 9	64 6	17 7
68	45 1	61 5	16 4
69	40 8	51 7	10 9
Total	70 1	80 3	10 2
60–64	87 8	92 1	4 3
65–69	48 7	64 8	15 1

* Source Great Britain, General Register Office Census 1951 One Per Cent Sample Tables Part I, Sec II Occupations (London H.M Stationery Office 1952), and R G Brown T M Keown and A G W Whitfield, Medical Fitness in Relation to Employment of Men Aged 60–69 in Proceedings of the Fourth Congress International Association of Gerontology Merano Italy (Fidenza, Italy Tipografia Tito Mattioli, 1959) 3, 101 19

Five companies with 829 employees offered the usual range of retirement benefits from social security and company pensions One company provided a much higher retirement income amounting to approximately two-thirds of the average of the last 5 years wages or salary (Table 15) These findings, if they can be generalized, give support to Dich's assumption of the effect of higher pensions on the desire to retire rather than to continue working In all companies the preference is for part time rather than for full time employment.

Additional supportive evidence for Dich's assumption is the low proportion of employed males 65 and over in Belgium (24 7 per cent reported for 1947), the lowest reported in western European countries This country requires retirement except for occasional work as a condition of eligibility for pensions At the same time the pension

TABLE 14*

PERCENTAGE OF OLDER WOMEN EMPLOYED AT SUCCESSIVE AGES 55–64 YEARS

Age	Women Employed	Age	Women Employed
55	30 5	60	18 7
56	28 4	61	15 2
57	27 7	62	13 6
58	27 5	63	12 3
59	24 3	64	11 6

* Source Great Britain, General Register Office Census 1951 One Per Cent Sample Tables Part I Sec II Occupations (London H.M Stationery Office, 1952)

TABLE 15*

PERCENTAGE WANTING TO WORK FULL AND PART TIME AFTER AGE 65

Employment Preference After 65	Retirement Income: Five Companies (Lower Income)	Retirement Income: One Company (High Income)
Full time	34 9	10 3
Part time	72 7	37 2

* Source E W Burgess and R. T Thornbury "Attitudes toward Working Full Time and Part Time of Older Employees (unpublished paper)

is relatively high—60 per cent for single persons or 75 per cent for married persons of average earnings during lifetime The earnings for each year are revalued by coefficient reflecting cost-of living changes (U S Department of Health, Education, and Welfare, 1958) The situation in Belgium may be compared with that of France, with a very low pension and no retirement eligibility for receiving it. In 1946 half (54 4 per cent) of the males 65 and over were reported as economically active (United Nations, 1956)

taken to prolong the working life of older persons?

A Trend to Retirement

The increase in retirement as a phenomenon in countries of Western culture may be seen in the figures showing the decrease of the percentage of men 65 years of age and over who were economically active in comparing the two periods around 1930 and 1950 (Table 12) During the period of approximately 20 years each country shows a decline, in most cases a marked decline, *in the proportion of those economically active* Where later figures are available, the decline is continuing It is evident that the percentage *of the retired men has in*creased and barring unforeseen contingencies, will continue to increase

TABLE 12*

PERCENTAGE DECREASE FROM 1930–31 TO 1950–51 OF MALE POPULATION 65 AND OVER *ECONOMICALLY ACTIVE*

COUNTRY	MALE POPULATION 65 AND OVER ECONOMICALLY ACTIVE	
	1930–31	1950–51
Australia	57 0	33 2†
Belgium	45 3	24 7‡
Canada	55 7	38 6
Denmark	41 7	35 9
France	59 4	36 1†
Great Britain	47 9	31 4
Italy	72 6	33 0§
Netherlands	42 6	35 5‡
Norway	53 1	42 1
Sweden	49 8	36 1
Switzerland	62 5	50 7
United States	58 3	41 4

* Source J Daric *Vieillissement de la population et prolongation de la vie active* (Paris Presses Universitaires de la France 1948), for early years and United Nations *Demographic Yearbook 1956* and International Labour Office *Statistical Yearbook 1956* for later years

† For 1954 ‡ For 1947 § For 1955

B Factors Affecting Retirement

Four factors will be considered in relation to their *effect upon the percentage* of older persons who are retired Two of these factors are societal They are (1) the adequacy of pensions and the existence of restrictions *on employment of older persons* and (2) the occupational structure as it adversely affects their employment opportunities *The two other factors are* individual They are (3) the adverse state of health of the person and (4) personal preference for retirement

ADEQUACY OF PENSIONS AND EXISTENCE *OF RESTRICTIONS ON EMPLOYMENT*

Dich (1959), a Danish gerontologist has stated that "the effect of higher pensions will always be that employees retire earlier *from work* " *Certainly, the existence* of an old age pension system combined with restrictions on working beyond an arbitrarily fixed age will result in an increase in the percentage of retired persons

Data from two sources (Great Britain, General Register Office, 1952, Brown *et al*, 1959) in Britain enable us to perceive the drop in employment of men 60–69 years of age by successive ages They also make possible a comparison between the country as a whole (1 per cent sample 1951 census) and in industrial area Birmingham (medical survey 1953) during a period of full employment (*Table 13*)

It is significant to note that the big drop in employed older persons comes at the pensionable age of 65 both for Great Britain (24 5 per cent) and for Birmingham (18 4 per cent) The drop is less for Birmingham than for Great Britain a fact which will be held for comment later

In the case of older female workers in Great Britain who are eligible for pensions at the age of 60 the drop in employment takes place over three years—59, 60, 61—as seen in Table 14 It appears that the combination of restrictions on employment and the availability of pensions affect the percentage of those who retire at the pensionable age

Dich (1959) contended that the effect of higher pensions would be to increase earlier retirement from work, but he admitted

that there were no empirical data to support his theoretical analysis Results of a recent American study provides inferential evidence (Burgess and Thornbury, 1960) A comparison is made of the replies of 1130 older employees 55–64 years of age to two statements "If I can I want to work full time after I am 65 and "After I am 65 I want to work part time to earn up to $1200 a year allowed by social security"

TABLE 13*

COMPARISON BETWEEN GREAT BRITAIN AND BIRMINGHAM IN THE EMPLOYMENT OF MALES 60–69

Age	Great Britain (1)	Birmingham (2)	Percentage Higher in Birmingham (2 − 1)
60	91 4	94 8	3 4
61	89 1	93 6	3 5
62	89 4	92 3	2 9
63	85 7	90 7	5 0
64	82 9	88 3	5 4
65	58 4	69 9	11 5
66	50 7	75 0	24 3
67	46 9	64 6	17 7
68	45 1	61 5	16 4
69	40 8	51 7	10 9
Total	70 1	80 3	10 2
60–64	87 8	92 1	4 3
65–69	48 7	64 8	15 1

* Source Great Britain General Register Office, *Census 1951 One Per Cent Sample Tables* Part I, Sec II *Occupations* (London HM Stationery Office 1952) and R G Brown T M Keown, and A G W Whitfield, Medical Fitness in Relation to Employment of Men Aged 60–69 in *Proceedings of the Fourth Congress, International Association of Gerontology Merano Italy* (Fidenza, Italy Tipografia Tito Mattioli, 1959) 3, 101 19

Additional supportive evidence for Dich's assumption is the low proportion of employed males 65 and over in Belgium (24 7 per cent reported for 1947), the lowest reported in western European countries This country requires retirement except for occasional work as a condition of eligibility for pensions At the same time the pension

TABLE 14*

PERCENTAGE OF OLDER WOMEN EMPLOYED AT SUCCESSIVE AGES 55–64 YEARS

Age	Women Employed	Age	Women Employed
55	30 5	60	18 7
56	28 4	61	15 2
57	27 7	62	13 6
58	27 5	63	12 3
59	24 3	64	11 6

* Source Great Britain, General Register Office *Census 1951 One Per Cent Sample Tables* Part I Sec II *Occupations* (London H M Stationery Office 1952)

TABLE 15*

PERCENTAGE WANTING TO WORK FULL AND PART TIME AFTER AGE 65

Employment Preference after 65	Retirement Income: Five Companies (Lower Income)	One Company (High Income)
Full time	34 9	10 3
Part time	72 7	37 2

* Source E W Burgess and R T Thornbury, "Attitudes toward Working Full Time and Part Time of Older Employees (unpublished paper)

Five companies with 829 employees offered the usual range of retirement benefits from social security and company pensions One company provided a much higher retirement income amounting to approximately two-thirds of the average of the last 5 years' wages or salary (Table 15) These findings if they can be generalized give support to Dich s assumption of the effect of higher *pensions* on the desire to retire rather than to continue working In all companies the preference is for part time rather than for full time employment.

is relatively high—60 per cent for single persons or 75 per cent for married persons of average earnings during lifetime The earnings for each year are revalued by coefficient reflecting cost of living changes (U S Department of Health, Education, and Welfare, 1958) The situation in Belgium may be compared with that of France with a very low pension and no retirement eligibility for receiving it. In 1946 *half* (54 4 per cent) of the males 65 and over were reported as economically active (United Nations, 1956)

OCCUPATIONAL STRUCTURE AND DIFFERENTIAL OPPORTUNITY FOR EMPLOYMENT

The position of the older person in the industrial and occupational structure markedly affects his chances of continuing in his regular occupation after 65 Certain types and kinds of occupations give little opportunity for employment and thus tend to force the older person into retirement Table 7 showed that for nine countries all but the United Kingdom and the United States had higher proportions of economically active males 65 and over who were either employers or working on their own account than those who were salaried employees and wage earners

Two countries, Sweden and the United Kingdom, give the breakdown between employers and those working on their own account In both countries there was a higher proportion of economically active males 65 and over compared with those 55–64 among those working on their own account than among employers (Sweden 78 9 and 28 6 per cent higher, England and Wales, 75 9 and 78 3 per cent higher)

Five countries report salaried employees and wage-earners separately (Belgium Denmark, the Netherlands, Sweden, and West Germany) In these countries there were much higher percentages of all those employed of wage earners than of salaried employees 65 and over still economically active than of those 55–64 (see Table 18) In Denmark the proportions were almost identical Only in Belgium is the percentage of salaried employees among older workers higher in comparison with those in the 55–64 age bracket

The census of 1951 1 per cent sample (Great Britain, General Register Office, 1952) provides data that are indicative of the differential chances of continuing employment after 65 by twenty seven industrial groups, as shown in Table 16 The third column of this table indicates the percentage that gainfully employed males 65–69 are of those age 60–64 occupationally active The inference is that this comparison is an approximate measure of the possibility of continuing work in each industry in the age group 65–69 It will be noted that the variability is wide, ranging from the lowest (12 2 per cent) among coal , gas , and cokemakers and workers in chemical and allied trades to the highest (83 3 per cent) among makers of products not elsewhere specified This industrial group is composed of workers in rubber, plastics, and molding, makers of musical instruments other than pianos, and other products Five other occupational groups with a percentage of 50 or higher employed in the age group 65–69 than in the age group 60–64 are persons in defense services (66 3 per cent), tanners etc , leather goods makers, fur-dressers (66 3 per cent), workers in wood cane and cork (65 3 per cent), agricultural, horticultural and forestry workers (56 3 per cent) commercial, finance and insurance workers (56 3 per cent) painters and decorators (51 8 per cent) and persons engaged in personal service (50 7 per cent)

The other occupational groups with lower chances than 40 per cent of employment for the age group 65 69 as compared with the age group 60–64 are workers in metal manufacture, engineering and allied trades (38 9 per cent), clerks typists etc (37 0 per cent) persons employed in transport and communication (28 4 per cent) and other and undefined workers (25 3 per cent)

HEALTH STATUS IN RELATION TO RETIREMENT

Certain older employees retire from their work or are retired by their employers because they are no longer physically fit to continue at their regular occupation A consideration of the health status of older persons raises certain questions What proportion of males 65 69 are fit for full time employment? What proportion of retired males 65–69 are fit for full time employment and willing to work and are employed? What proportion of retired males

65–69 are fit for full time employment but cannot find work? What proportion of retired males 65–69 are unfit for full time work and what percentage of these are gainfully employed?

A searching study was made in Birmingham, England, of the relation of medical fitness to employment of 1062 men aged 60–69 inclusive Their fitness was assessed by eleven practitioners. Of special interest are the medical findings on 458 men aged 56–69 (Brown *et al*, 1959). Three-fourths (74 4 per cent) were reported to be fit for their original employment, and 11.6 per cent were regarded as unfit for their original employment but fit for other work (or a total of 86 per cent fit for work). Fourteen per cent were considered to be unfit for any employment. Of the 86 per cent fit to work, 63 7 per cent were employed; 4 4 per cent of the remainder wished to work; and 17.9 per cent did not wish to work Of the 14 0 per cent unfit for any work, 1 1 per cent were employed, leaving 12 9 per cent unfit for work and unemployed Evidently, the findings of this study

TABLE 16*

PERCENTAGE OF MALES IN GREAT BRITAIN OCCUPIED AT AGES 60–64, 65–69, AND 70 AND OVER

Occupation	Age			Percentage Age 65–69 Is of 60–64
	60–64	65–69	70 and Over	
1 Fishermen	2 2	1 0	2 0	45 5
2 Agricultural, horticultural, and forestry workers	78 7	44 3	46 3	56 3
3 Mining and quarrying workers	39 7	19 5	5 9	49 1
[illegible]	3 0	1 4	7 0	46 7
[illegible]	4 9	0 6	5 0	12 2
[illegible] workers	107 1	41 7	17 0	38 9
7 Textile workers	17 8	7 4	4 2	41 6
8 Tanners etc [illegible]	9 2	6 1	3 2	66 3
[illegible]	8 6	4 1	4 7	47 7
[illegible]	9 8	4 2	2 2	42 9
[illegible]	25 9	16 9	7 1	65 3
[illegible]	11 0	5 1	3 9	46 4
[illegible]	2 4	2 0	1 2	83 3
[illegible]	56 9	26 8	12 9	47 1
[illegible]	16 6	8 6	4 8	51 8
[illegible]	31 4	14 1	13 0	44 9
[illegible]	85 2	24 2	13 4	28 4
[illegible]	83 3	46 9	41 0	56 3
[illegible]	36 7	18 2	14 5	49 6
[illegible]	16 0	10 6	9 9	66 3
22 Persons engaged in personal service (including hotels, institutions clubs)	5 6	2 7	2 3	48 2
23 Clerks, typists etc	47 9	24 3	17 2	50 7
24 Warehousemen, storekeepers, packers, bottlers	51 4	19 0	11 7	37 0
25 Stationary engine-drivers, crane-drivers, tractor-drivers, stokers, etc	31 7	13 3	6 4	42 0
26 Workers in unskilled occupations not elsewhere specified	21 3	8 6	3 1	40 4
27 Other and undefined workers	104 4	48 2	24 8	46 2
	9 5	2 4	8 0	25 3

* Source *Great Britain*, General Register Office, *Census 1951 One Per Cent Sample Tables*, Part I, Sec. II *Occupations* (London H.M. Stationery Office, 1952), Table II.3

indicate that, of the 35.2 per cent of the retired men 65–69 years of age, 12.9 per cent could be attributed to state of health and 22.3 per cent to other reasons. But Birmingham is an industrial area, and the period of the study was one of full employment.

Is it feasible to adapt these findings to Great Britain? The assumption will be made that the percentage of the unfit to work among males 65–69 will be the same for the whole country as for Birmingham. Under this assumption the percentage of the unfit to work will also be 14 per cent. But the percentage of retired males 60–65 for Great Britain was 51.3 instead of 35.2, as in Birmingham. Accordingly, our estimate is that about three of every eight males 65–69 in Great Britain are retired due to reasons other than health.

The Birmingham study also analyzed the percentage of men considered fit to be employed by age from 60 to 69 and by those retired and still employed. The findings are presented in Table 17. Three points emerge from an examination of this table that deserve comment. (1) The percentage of older men judged to be unfit for employment remains relatively low during the ages studied and only reaches a peak of one in four (23.6 per cent) at 69 years. (2) The percentage of retired men who are fit for employment but not wishing to work makes a big jump from 4.5 per cent at age 60 to 17.5 at age 65. The fact that one in every six men at age 65 takes advantage of his eligibility for a pension and, although capable, does not wish to continue working demonstrates the relation of a pension system to retirement. (3) The findings presented indicate that for retired persons in Birmingham personal preference not to work is a more important factor in making for retirement than medical unfitness for employment.

TABLE 17*

PERCENTAGE OF MEN CONSIDERED TO BE FIT FOR EMPLOYMENT

Age	Employed Men		Retired Men		
	Fit	Unfit	Fit and Wish To Work	Fit and Do Not Wish To Work	Unfit
60	93.1	1.7		0.9	4.3
61	90.7	2.9		2.9	3.6
62	90.0	2.3	0.8	3.1	3.8
63	89.8	0.9	0.9	0.9	7.4
64	87.4	0.9	2.7	4.5	4.5
65	68.9	1.0	3.9	17.5	8.7
66	72.9	2.1	1.0	17.7	6.3
67	63.3	1.3	8.8	11.4	15.2
68	60.4	1.1	5.5	20.9	12.1
69	51.7		3.4	21.3	23.6
Total	78.8	1.5	2.4	9.1	8.2
60–64	90.2	1.8	0.8	2.5	4.7
65–69	63.7	1.1	4.4	17.9	12.9

* Source: R. G. Brown, T. McKeown, and A. G. W. Whitfield, "Medical Fitness in Relation to Employment of Men Aged 60–69," in *Proceedings of the Fourth Congress, International Association of Gerontology, Merano, Italy* (Fidenza, Italy: Typografia Tito Mattioli, 1959), 3: 101–19.

In this industrial area it is evident that there is no substantial reservoir of fit men who are willing to work in the age group 65–69. But the proportion of all men 65–69 who are unfit for employment is small. Consequently, the investigators make the point that, "if an advancement of age of

retirement were considered desirable for other reasons, there appear to be no medical grounds which would prohibit it'

PERSONAL PREFERENCE

Personal preference for retirement is an omnibus category covering many different reasons other than those previously considered In a sample of one of fifty Parisian workers who had received their old age pension a year or less, Tréanton (1959) reports that 23 per cent state that they stopped working of ' their own will " Nearly half (47 per cent) gave reasons of health or fatigue and a quarter (26 per cent) were forced to retire

age in these occupational statuses for five European countries

It is interesting to note the marked increase in the age group 65 and over as compared with the age group 55–64 in employers and those on own account who are still employed Correspondingly the [illegible]

ployees and in three of the five countries for wage-earners

The actual numbers, of course, in all these occupational groups decline after the pensionable age The point is that personal preference to continue working finds greater expression in continued employment

TABLE 18*

PERCENTAGE EMPLOYED BEFORE AND AFTER 65 BY OCCUPATIONAL STATUS

COUNTRY AND YEAR	EMPLOYERS AND ON OWN ACCOUNT		SALARIED EMPLOYEES		WAGE EARNERS	
	55–64	65 and Over	55–64	65 and Over	55–64	65 and Over
Belgium (1947)	36 0	67 7	16 2	10 9	46 7	18 9
Denmark (1950)	43 7	58 1	17 4	12 7	38 9	29 2
West Germany (1950)	33 2	68 2	24 9	8 8	41 2	20 5
Netherlands (1947)	37 3	61 8	17 3	7 3	42 4	29 2
Sweden (1950)	35 8	60 8	19 2	8 8	44 3	33 4

* Source United Nations *Demographic Year book 1956* Table 14

The Birmingham study (Brown *et al*, 1959) indicates that half the men 65–69 who had retired did not wish to continue working although the medical examination found them fit for full time employment. This proportion would undoubtedly be smaller for Great Britain as a whole, or about one-third according to our estimate

One way of estimating the influence of personal preference on retirement is to eliminate or at least to reduce the effect of being forced to retire This can be done by comparing the percentage of those retiring who can determine when they retire (employers and those working on their own account) with those where the decision is made for them (salaried employees and wage-earners) Table 18 gives the percentage of men before and after 65 years of

among employers and those working on their own account than with salaried employees and wage-earners

It is apparent that the four factors examined—the adequacy of pensions and restrictions on employment, the occupational structure with differential work opportunities the health status of the older person, and personal preference—are all conditions making for or against retirement Research, however, is needed to determine more precisely how these and other factors operate independently and in conjunction to affect retirement behavior

C The Prolongation of Working Life

In France, Great Britain, the United States, and other countries there has been

a lively interest in prolonging the working life of older people. In 1948 Jean Daric published his book *Le Vieillissement de la population et prolongation de la vie active.* In it he examines the economic and social consequences of the aging of the population, analyzes the available data on aging from a special public opinion poll conducted by l'Institut National d'Études Demographiques, reviews the objections against and the arguments in favor of the prolongation of working life, and discusses the possibilities of a policy aimed at lengthening the working life of older persons.

TABLE 19*

PART TIME WORKERS AS PERCENTAGE OF ALL EMPLOYED PERSONS BY AGE

Age	Men	Women
60-64	0 6	16 4
65-69	2 3	17 0
70-74	5 9	12 2
75 and over	6 7	6 1

* Source F L G Clark, "Would Short [illegible]

Daric (1955) reports the findings of a survey of elderly workers in France. Special provisions to help older employees were found in only a few firms These provisions include their placement in light work, transfer to different jobs where the hours and speed of work can be modified, assignment to special work groups, and the introduction of homework.

Abrams (1955) enumerates a few measures undertaken by governments to encourage employment of older persons, such as the setting-aside of public jobs for the elderly by Denmark, subsidies to employers hiring the aged by Switzerland, and training centers under governmental auspices in France, Italy, Belgium, and Switzerland He recommends that the effectiveness of these measures should be evaluated.

These projects listed by Daric and by Abrams are only a few of the many attempts to provide special employment for the elderly or to improve their work skills by retraining. Other investigators have been concerned with broader changes in employment policies and practices

F. L. G Clark (1959) is concerned with the question, "Would short working hours prolong employment for the elderly?" In other words, can a person when no longer fit for full-time work find part-time employment? He utilizes the data of the national census of April, 1951, which reports 51,576 women and 28,467 men 60 and over as holding part-time employment. The proportion of men but not of women in part-time gainful employment increases with age, as shown in Table 19

TABLE 20*

PERCENTAGE PART TIME MALE WORKERS IN TEN OCCUPATIONS BY AGE GROUPS

Occupation	All Men Employed in Same Occupation		
	60 64	65 69	70 and Over
Clerks	1 6	4 5	10 2
Shop assistants	2 5	9 0	19 4
Teachers (not music teachers)	3 0	20 0	22 5
Caretakers	3 5	12 7	21 8
Farm workers	1 5	6 4	16 2
Gardeners (mainly jobbing)	3 2	9 9	23 1
Warehousemen	0 3	1 8	5 8
Office cleaners	6 4	20 0	36 2
Kitchen porters	2 2	6 7	14 2
Watchmen	2 3	5 5	11 5

* Source Great Britain, General Register Office Census 1951 *One Per Cent Sample Tables* Part I Sec II Occupations (London H M Stationery Office 1952)

Ten occupations account for more than half the male part-time employees in Britain according to the 1951 census (Great Britain, General Register Office, 1952) All these show increasing proportions with successive ages, although, of course, the actual numbers of men at work decrease with age (Table 20). Part-time work, at least for older men, accounts at present for only a

small percentage of those still employed after 65 years of age It is confined to a limited number of occupations. Can it be further expanded?

Part time employment is an attractive method of prolonging the working life of older persons It would utilize the services of many not capable of, or, if capable, not desiring full time employment But Le Gros Clark (1959) is skeptical of the possibilities of overcoming the resistance in manufacturing industries to the extension of the practice of part time employment for elderly persons. He sees, however, no reason why part time work for older men and women should not expand considerably in many offices, shops, and retail stores, where a measure of flexibility is more feasible than in industry He also points out that professional persons often have the opportunity of adjusting their hours of work to suit their physical convenience

Barbara Shenfield (1955) analyzed the employment status of persons 65–69 years as shown by the 1 per cent sample report of the British census (Great Britain, General Register Office, 1952) She was interested [illegible]

[illegible] pected to absorb a considerable number of persons beyond retirement age She concluded that ' there is no immediate prospect of a sub tantial increase in the numbers employed who are over pensionable age ' (p 312)

The prospects for an expansion of the volume of emplo [illegible]

[illegible] culture shows a continuing decline in the proportion of the economically active of those above pensionable age There is no evidence of the emergence of counteracting factors.

There remains the question of how great a hardship this situation will impose upon the older person There is evidence that gerontologists would be well advised to direct their attention away from providing more employment to the problem of the older worker of pensionable age who continues to work not because he prefers to do so but because of financial necessity

The opinion of 71 per cent of those polled in Great Britain in the world poll of 1958 reported that the old age benefits were "too low" (International Research Associates, 1958) In the countries canvassed this reply was exceeded only by Italy (76 per cent) and by France (87 per cent) Belgium, which has a relatively adequate system of benefits, has, as we have seen, a low proportion of males 65 and over employed (24 7 per cent) Reference has already been made to a comparison of the older employees of one company with a high retirement benefit system with five other companies with lower benefits, with 10.3 per cent in the former and 37 2 per cent in the latter wanting to work full time after age 65

The proportion of older persons who continue to work because of financial pressure is large In the 1953 investigation of the Ministry of Pensions and National Insurance (1954) the chief reason given by British workers for continuing employment beyond the minimum pensionable age was financial need (44 7 per cent) Only one in five (20 2 per cent) stated that they prefer to work In the Birmingham study (Brown *et al*, 1959) the proportion reporting financial need was even higher (78 5 per cent) as the reason for still working Again only one in five (20 5 per cent) gave personal preference as their reason for being employed

Three pressures impinge upon persons which force them to retire These are ill-health, age restrictions, and lack of opportunity for employment

The chief pressure forcing men and women to remain in the labor force is financial need This problem can be met by increasing pensions or other sources of retirement income to provide an adequate level of benefits

The optimum situation would appear to

a lively interest in prolonging the working life of older people. In 1948 Jean Daric published his book *Le Vieillissement de la population et prolongation de la vie active*. In it he examines the economic and social consequences of the aging of the population, analyzes the available data on aging from a special public opinion poll conducted by l'Institut National d'Études Démographiques, reviews the objections against and the arguments in favor of the prolongation of working life, and discusses the possibilities of a policy aimed at lengthening the working life of older persons.

TABLE 19*

PART-TIME WORKERS AS PERCENTAGE OF ALL EMPLOYED PERSONS BY AGE

Age	Men	Women
60-64	0.6	16.4
65-69	2.3	17.0
70-74	5.0	12.2
75 and over	6.7	6.1

* Source: F. L. G. Clark, "Would Short Working Hours Provide Employment for the Elderly?" in *Proceedings of the Fourth Congress, International Association of Gerontology* [illegible] [illegible] Tipografia [illegible] [illegible]

Daric (1955) reports the findings of a survey of elderly workers in France. Special provisions to help older employees were found in only a few firms. These provisions include their placement in light work, transfer to different jobs where the hours and speed of work can be modified, assignment to special work groups, and the introduction of homework.

Abrams (1955) enumerates a few measures undertaken by governments to encourage employment of older persons, such as the setting-aside of public jobs for the elderly by Denmark, subsidies to employers hiring the aged by Switzerland, and training centers under governmental auspices in France, Italy, Belgium, and Switzerland. He recommends that the effectiveness of these measures should be evaluated.

These projects listed by Daric and by Abrams are only a few of the many attempts to provide special employment for the elderly or to improve their work skills by retraining. Other investigators have been concerned with broader changes in employment policies and practices.

F. L. G. Clark (1959) is concerned with the question "Would short working hours prolong employment for the elderly?" In other words, can a person when no longer fit for full-time work find part-time employment? He utilizes the data of the national census of April 1951, which reports 51,576 women and 23,457 men 60 and over as holding part-time employment. The proportion of men but not of women in part-time gainful employment increases with age, as shown in Table 19.

TABLE 20*

PERCENTAGE PART-TIME MALE WORKERS IN TEN OCCUPATIONS BY AGE GROUPS

Occupation	[illegible]		
	[illegible]	[illegible]	[illegible] and Over
Clerks	1.0	4.5	13.2
Shop assistants	2.5	9.0	15.4
Teachers [illegible] teachers	3.0	10.0	22.5
Caretakers	3	13	21
Farm workers	1.5	6.4	15.2
Gardeners (mainly public)	3.2	6.0	[illegible]
Warehousemen	0	1.5	5.5
Office cleaners	6.4	10.0	[illegible]
Kitchen porters	[illegible]	6	14.2
Watchmen		5.5	11

* Source: Great Britain General Register Office, *Census 1951, One Per Cent Sample Tables, Part I* [illegible] London: H.M. Stationery Office, 19[illegible]

Ten occupations account for more than half the male part-time employees in Britain, according to the 1951 census (Great Britain General Register Office, 1952). All these show increasing proportions with successive ages, although of course the actual numbers of men at work decrease with age (Table 20). Part-time work, at least for older men, accounts at present for only a

small percentage of those still employed after 65 years of age It is confined to a limited number of occupations Can it be further expanded?

Part time employment is an attractive method of prolonging the working life of older persons It would utilize the services of many not capable of, or, if capable, not desiring full time employment But Le Gros Clark (1959) is skeptical of the possibilities of overcoming the resistance in manufacturing industries to the extension of the practice of part time employment for elderly persons He sees however, no reason why part time work for older men and women should not expand considerably in many offices shops and retail stores where a measure of flexibility is more feasible than in industry He also points out that professional persons often have the opportunity of adjusting their hours of work to suit their physical convenience

Barbara Shenfield (1955) analyzed the employment status of persons 65 69 years as shown by the 1 per cent sample report of the British census (Great Britain General Register Office 1952) She was interested in exploring whether industries with a relatively high or those with a relatively low proportion of older workers might be expected to absorb a considerable number of persons beyond retirement age She concluded that there is no immediate prospect of a substantial increase in the numbers employed who are over pensionable age (p 312)

The prospects for an expansion of the volume of employment for persons 65 years of age and older do not appear to be bright The secular trend in all countries of Western culture shows a continuing decline in the proportion of the economically active of those above pensionable age There is no evidence of the emergence of counteracting factors

There remains the question of how great a hardship this situation will impose upon the older person There is evidence that gerontologists would be well advised to direct their attention away from providing more employment to the problem of the older worker of pensionable age who continues to work not because he prefers to do so but because of financial necessity

The opinion of 71 per cent of those polled in Great Britain in the world poll of 1958 reported that the old age benefits were "too low (International Research Associates 1958) In the countries canvassed this reply was exceeded only by Italy (76 per cent) and by France (87 per cent) Belgium which has a relatively adequate system of benefits has, as we have seen a low proportion of males 65 and over employed (24 7 per cent) Reference has already been made to a comparison of the older employees of one company with a high retirement benefit system with five other companies with lower benefits, with 10.3 per cent in the former and 37 2 per cent in the latter wanting to work full time after age 65

The proportion of older persons who continue to work because of financial pressure is large In the 1953 investigation of the Ministry of Pensions and National Insurance (1954) the chief reason given by British workers for continuing employment beyond the minimum pensionable age was financial need (44 7 per cent) Only one in five (20 2 per cent) stated that they prefer to work In the Birmingham study (Brown *et al*, 1959) the proportion reporting financial need was even higher (78 5 per cent) as the reason for still working Again only one in five (20 5 per cent) gave personal preference as their reason for being employed

Three pressures impinge upon persons which force them to retire. These are ill health age restrictions and lack of opportunity for employment

The chief pressure forcing men and women to remain in the labor force is financial need This problem can be met by increasing pensions or other sources of retirement income to provide an adequate level of benefits

The optimum situation would appear to

be one in which a man or woman at 65 would freely choose without external pressure whether to continue employment or to retire The obstacle of ill health may be reduced by medical science and public health education Age restrictions may be modified by scientific evidence showing that older workers are as productive as young workers (Burns and Spaeth, 1960) Opportunity for work may be obtained as those now forced by financial need to work against their will can enjoy retirement

The present system of arbitrary employment policies and practices and of inadequate pensions is a combination of contradictions It forces persons from financial need to continue working who would prefer to retire and others to retire who would prefer to continue working Once practical measures are taken to end compulsion in employment and in retirement there will be full employment for all that wish to continue working

In this chapter we have been concerned with retirement from the standpoint of the factors influencing persons at pensionable age to retire or to continue gainful employment In succeeding chapters other aspects of retirement and life after 65 will be considered, such as income maintenance, housing and community services physical and mental health family structure and relationships, and life beyond the family and work The center of interest will shift from the opportunity of employment beyond pensionable age to providing the opportunities in retirement for a new way of life

REFERENCES AND BIBLIOGRAPHY

ABRAMS, A J 1955 Discrimination against older works in various countries *In* Old age in the modern world pp 291–95 Edinburgh E & S Livingstone

BROWN R G McKEOWN T, and WHITFIELD, A G W 1959 Medical fitness in relation to employment of men aged 60–69 *In* Proceedings of the Fourth Congress International Association of Gerontology Merano Italy 3, 101–8 Fidenza Italy Tipografia Tito Mattioli

BURGESS E W and THORNBURY R. T 1960 Attitudes toward working full time and part time of older employees (Unpublished paper)

BURNS, R K, and SPAETH J L 1960 Productivity and aging *In* R K BURNS (ed) Objective criteria of aging and determinants of retirement Chicago University of Chicago Press

CLARK, F L G 1959 Would short working hours prolong employment for the elderly? *In* Proceedings of the Fourth Congress International Association of Gerontology Merano Italy 3, 109–19 Fidenza Italy Tipografia Tito Mattioli

DARIC J 1948 Vieillissement de la population et prolongation de la vie active (Institut Nationale d Études Démographiques Travaux et Documents' No 7) Paris Presses Universitaires de France

——— *1955* Survey of the employment of elderly workers in France *In* Old age in the modern world pp 295 99 Edinburgh E & S Livingstone

DEPOID P 1951 Tables françaises concernant la population masculine (1906–1946) Bull Internat. Statistical Institute, Vol 33, Part IV Demography and labour statistics pp 131–46

DICH J S 1959 The economic political consequences of an ageing population *In* Proceedings of the Fourth Congress International Association of Gerontology Merano Italy, 3 77–85 Fidenza Italy Tipografia Tito Mattioli

GREAT BRITAIN COMMITTEE ON THE ECONOMIC AND FINANCIAL PROBLEMS OF THE PROVISION FOR OLD AGE 1954 Report (Cmd 9333) London H M Stationery Office

GREAT BRITAIN GENERAL REGISTER OFFICE 1952 Census 1951 one per cent sample tables Part I Sec II Occupations London H M Stationery Office

GREAT BRITAIN MINISTRY OF PENSIONS AND NATIONAL INSURANCE 1954 Reasons given for retiring or continuing at work London H M Stationery Office

INTERNATIONAL LABOUR ORGANIZATION 1956 Yearbook of labour statistics Geneva International Labour Organization

INTERNATIONAL RESEARCH ASSOCIATES 1958 World poll New York Herald Tribune October 11–12

MORTARA G 1951 Durée de la vie économiquement active suivant la mortalité Bull Internat Statistical Institute Vol 33, Part

IV Demography and labour statistics, pp 147–74

Naville, P 1959 Measurement of working life and employment of older workers in France *In* C. Tibbitts (ed.), Aging and social health in the United States and Europe, pp 74–93 Ann Arbor Division of Gerontology, University of Michigan.

New Zealand 1955 Table of working life, 1951 male population (including Maoris) Wellington, N.Z. Census and Statistics Department.

Organization for European Economic Co-operation 1956 Demographic trends in western Europe a report by the Manpower Committee Paris The Organization

Shenfield, Barbara E 1955 Employment prospects for older workers in Great Britain *In* Old age in the modern world, pp 305–12 Edinburgh E & S Livingstone

Titmuss, R M 1959 Essays on the welfare state New Haven, Conn Yale University Press

Tréanton, J R. 1959 Adjustment of older people to urban life in France *In* C Tibbitts (ed), Aging and social health in the United States and Europe, pp 167–73 Ann Arbor Division of Gerontology, University of Michigan.

New York United Nations.

U S Department of Health, Education, and Welfare, Social Security Administration 1958 Social security programs throughout the world, 1958 Washington, D C Government Printing Office.

U S Department of Labor 1955 Our manpower future Washington, D C Government Printing Office

Wolfbein, S L. 1959 The length of working life *In* Proceedings of the Fourth Congress, International Association of Gerontology, Merano, Italy, 3, 153–84 Fidenza, Italy. Tipografia Tito Mattioli.

IV

Income Maintenance and Medical Insurance

WILBUR J. COHEN

I Brief Summary of Status of Present Programs

At the end of 1958, fifty seven countries throughout the world had some type of government sponsored income maintenance program providing benefits for aged (and disabled) persons, and almost as many countries also had some type of government sponsored medical insurance or medical service program which pays for the costs or provides medical care for all or large groups in the population often including the aged who have retired and the disabled

These programs are usually, but not always, nation wide in their geographical scope and, in a few cases are universal in their application throughout the nation in that all aged persons are eligible for benefits In some cases they may be limited initially to principal urban areas or to certain industrial or occupational groups This is particularly true when plans are in the early stages of evolution such as in newly developing countries In some countries the plans may not be universal in character but may cover a very large proportion of the population The plans may be organized and administered by public authorities or may utilize quasi governmental or non governmental agencies Financing may involve payroll taxes, general government contributions or subsidies, or some combination of these approaches The principles of insurance and assistance, or both, may be used, although the former is predominant In a few countries insurance and assistance principles may be combined in the same program

Illustrations may also be found of countries in which old age benefits or health services are provided on a universal basis as a matter of right, with little or no reliance on the past contributions of individuals However, not all countries with such national programs have applied the same principles equally to income maintenance and health programs Historical developments, traditions, culture and economic and social developments all play a significant role in determining the evolution and type of social security institutions of different countries

There is a wide variation in the specific characteristics of the plans used in different countries to provide income and health protection in old age Despite the variations, there are many similarities in the plans and experiences of countries with these income and health programs which have had, and will continue to have, value and pertinence to programs and developments in the United States

Policies and programs with respect to providing income and medical care to aged persons raise many important complex, and controversial issues Throughout the world individuals and organizations, voluntary and public agencies, political and professional associations, and governments, over many years have struggled with these same basic issues

A major factor in the development and expansion of income and health programs in Western countries in the last 75 years has been the desire of peoples and governments for some protection against the major economic and social hazards of life without recourse to charity Out of this grew the social insurance movement in Europe beginning in Germany in 1883, which ultimately spread to the United States in the early part of the twentieth century through workmen's compensation which provided cash wage-loss benefits and medical care for work-connected accidents

The same kinds of problems which gave rise to the social insurance movement in Europe also ultimately resulted in the development of the same kinds of social insurance institutions in the United States Today, as in the last 75 years the experiences of Western countries the United States and other countries of the world in the social security field are *interacting* upon one another The whole process in both Europe and the United States *is* still *in* a stage of growth and change A number of divergent tendencies *and forces* are at work in different countries which make it hazardous to isolate the important current trends of significance for the future development of social security in the United States It is possible, however, to record some of the more significant developments in western European countries which have had an impact upon the social security system of the United States or which ma the [illegible]

[illegible] ... ected developments and issues

A Extent and Character of Old Age Programs

When the United States Congress de cided [illegible] gra [illegible] 19 [illegible] act [illegible] of the twenty-seven European countries Germany had inaugurated such a system for invalidity and old age insurance in 1889 Denmark established a national old age assistance plan in 1891 Great Britain enacted an old age assistance program in 1908, an invalidity insurance program in 1911, and then added old age and survivors insurance in 1925 Sweden established its program, which has features of insurance, pensions and assistance, in 1913 Only Albania, Finland, Norway, Switzerland and Turkey, of the European countries, did not have old age benefit programs by 1935

It is interesting to note that "invalidity" insurance (or what *is called in* the United States "permanent total disability insurance) in effect preceded old age insurance in both *Germany and Great Britain* whereas, in the United States disability insurance was not added to the old age insurance program until 21 years later (1956), although federal grants to the states for *disability* assistance to needy individuals had been added to the over-all social security program in the United States a few years earlier (1950), survivors insurance benefits for widows and orphans had been added in 1939 Governmental health insurance programs preceded old age insurance programs in both Germany and Great Britain

When the executive branch of the United *States* was considering adoption of the original *old* age insurance plan in 1934, there were only twenty eight countries with general old age insurance or pension programs in the world, of *which* twenty two were in Europe, the other six being Australia, Brazil Chile, New Zealand, Union of South Africa, and Uruguay The European experience was thus the most important in the minds of the staff of the Committee on Economic *Security* which drew up the old age insurance plan The most important of the European systems in 1934 were those of Germany and Great Britain, both of which then had a uniform pensionable age *of 65 in* their contributory insurance programs but had very different types of benefit programs, with some experience

under a wide range of conditions such as war, depression, inflation, and deflation

When the Committee on Economic Security, established by President Franklin D Roosevelt in 1934 to draft the Social Security Act, came into being, one of the first duties of its staff was to make a survey of the main European experience in social insurance and public assistance The report of the staff of the committee, *Social Security in America* (1937), contains a list of the staff studies made and indicates the substantial extent to which reference was made to the European experience Of even more significance is the fact that the senior members of the policy and research staffs were familiar with the European experience from firsthand study Thus the European experience had a pertinent bearing on a number of the policy decisions incorporated in the original 1934–35 proposals

Since 1935, the remaining five European countries have adopted old age benefit programs The countries, and the dates of adoption of their programs, are as follows Norway, 1936, Finland, 1937, Switzerland 1946, Albania, 1947, and Turkey, 1949

Thus as of 1958, all European countries have some old age benefit program Counting both East and West Germany as separate countries, there are twenty eight countries in Europe with programs These programs usually—but not always—combine benefits for the aged, the disabled, and the widows and orphans (survivors) There are wide variations in the approach, scope, adequacy, financing types of benefits, and administration in these programs The experience of these countries offers a rich opportunity to the student of social security to find many variations of provisions operating under diverse conditions, with almost constant changes of provisions to meet new and changing needs

B Extent and Character of Medical Insurance Programs

All the European countries except Finland have some kind of government sponsored medical insurance or medical service program which pays for part or all of the costs or provides medical care for all or large groups in the population, often including the aged and the disabled A government sponsored plan for health insurance was first established in Germany in 1883 In Great Britain a limited governmental health insurance program was established by Lloyd George in 1911 The systems spread to many countries throughout Europe and the rest of the world The United States is almost alone among the major industrial countries of the world which do not have some kind of government sponsored health insurance or medical care program for at least large groups of industrial workers Some governmental measures exist for special groups in the United States, such as veterans, seamen Indians, persons in military service, public assistance recipients, injured workmen, the mentally ill, and the tubercular In addition, one state, California, has a government health insurance program limited to hospital insurance for employees covered under its unemployment insurance and cash sickness benefits program

The controversial nature of medical insurance in the United States under any kind of public auspices has led to frequent examination of the European experience by both the opponents and the advocates of various measures There are those who claim that any kind of public responsibility for any medical care insurance inevitably leads to "socialized medicine" Great Britain is usually cited as an example for this claim since it now has a universal, public medical care program On the other hand there are those who claim that the experience of countries on the European continent demonstrates that a publicly sponsored or financed health insurance system is a bulwark against the adoption of a public medical service plan for the entire population

It is not likely that this kind of an argument can be resolved by reference to any generalization based upon European expe

nence Suffice it to say that countries of varying background and with varying economic and political ideologies—Ireland Sweden Spain Yugoslavia—have some kind of health insurance program under public auspices

Although it has not been possible to verify the statement by checking with every country, it is not believed that there exists in Europe a separate publicly financed hospital insurance program solely for the beneficiaries of the social security system such as has been proposed in the Congress of the United States (usually referred to as the 'Forand Bill) Because the health insurance and service programs of European countries deal with general groups in the population, it has not been possible to determine whether any important special arrangements have been made for the aged which are not applicable to younger persons in a group Ireland appears to be the only country which provides for only hospital care to insured workers An evaluation of the experience of countries providing hospital coverage remains an area for additional research An appendix summarizes the medical-care insurance provisions for pensioners in ten western European countries

II Old Age Programs—General

Every old age program in every country is different from that of another country Human ingenuity being what it is there is most likely to be a tendency toward further variations of details in the programs for the future On the other hand there are some general types of programs which can be classified if it is remembered that social institutions have many facets which prevent clear-cut classifications which do not overlap

A Types of Old Age and Disability Programs in the United States

Such terms as 'insurance' and "assistance are subject to varying interpretations in different countries It might be best to see, in a general way, how these terms are used in the United States before attempting to summarize European plans

In the United States there are five main types of old age and disability programs of public concern

1 The contributory wage related old age insurance program with which is combined survivors and permanent total disability insurance This program is operated by the federal government
2 The state old age assistance permanent total disability assistance and blind assistance programs for needy individuals financed in part by federal grants in aid under very general federal standards
3 State or local general assistance or 'poor relief statutes applicable to needy older people who for one reason or another (such as premature old age or not meeting state residence or other requirements), are not eligible for federally aided old age or disability assistance
4 Supplemental old age and disability pension plans established by employers by unions or by collective bargaining which except for very general approval by the tax or insurance authorities for tax-deduction or investment purposes are not subject to public control as to the characteristics of their financing or benefit provisions
5 Savings or profit-sharing plans for old age and disability similar to those enumerated under No 4 above

B Types of Programs in Western Europe

It is not possible to take the classification which is useful in the United States and use it for comparison with other countries without some modification Some countries have adopted an old age program which is neither strictly "insurance' nor 'assistance," in the way these terms sometimes are used in the United States In some European countries there is a truly universal old age pension program providing benefits to everyone meeting the age and residence requirements Among the European countries, Denmark, Finland, Norway and Sweden have programs which

under a wide range of conditions such as war, depression, inflation, and deflation

When the Committee on Economic Security, established by President Franklin D Roosevelt in 1934 to draft the Social Security Act, came into being, one of the first duties of its staff was to make a survey of the main European experience in social insurance and public assistance The report of the staff of the committee, *Social Security in America* (1937), contains a list of the staff studies made and indicates the substantial extent to which reference was made to the European experience Of even more significance is the fact that the senior members of the policy and research staffs were familiar with the European experience from firsthand study Thus the European experience had a pertinent bearing on a number of the policy decisions incorporated in the original 1934–35 proposals

Since 1935, the remaining five European countries have adopted old age benefit programs The countries, and the dates of adoption of their programs, are as follows Norway, 1936, Finland, 1937, Switzerland 1946, Albania, 1947, and Turkey, 1949

Thus, as of 1958, all European countries have some old age benefit program Counting both East and West Germany as separate countries, there are twenty eight countries in Europe with programs These programs usually—but not always—combine benefits for the aged, the disabled, and the widows and orphans (survivors) There are wide variations in the approach, scope, adequacy, financing, types of benefits, and administration in these programs The experience of these countries offers a rich opportunity to the student of social security to find many variations of provisions operating under diverse conditions with almost constant changes of provisions to meet new and changing needs

B Extent and Character of Medical Insurance Programs

All the European countries except Finland have some kind of government sponsored medical insurance or medical service program which pays for part or all of the costs or provides medical care for all or large groups in the population, often including the aged and the disabled A government sponsored plan for health insurance was first established in Germany in 1883 In Great Britain a limited governmental health insurance program was established by Lloyd George in 1911 The systems spread to many countries throughout Europe and the rest of the world The United States is almost alone among the major industrial countries of the world which do not have some kind of government sponsored health insurance or medical care program for at least large groups of industrial workers Some governmental measures exist for special groups in the United States, such as veterans, seamen, Indians persons in military service, public assistance recipients, injured workmen, the mentally ill, and the tubercular In addition, one state, California, has a government health insurance program limited to hospital insurance for employees covered under its unemployment insurance and cash sickness benefits program

The controversial nature of medical insurance in the United States under any kind of public auspices has led to frequent examination of the European experience by both the opponents and the advocates of various measures There are those who claim that any kind of public responsibility for any medical care insurance inevitably leads to "socialized medicine" Great Britain is usually cited as an example for this claim, since it now has a universal, public medical care program On the other hand there are those who claim that the experience of countries on the European continent demonstrates that a publicly sponsored or financed health insurance system is a bulwark against the adoption of a public medical service plan for the entire population

It is not likely that this kind of an argument can be resolved by reference to any generalization based upon European expe

supplementary payments are given to meet nursing home and medical-care costs

C Equity and Adequacy in Old Age Programs

One of the persistent problems in income-maintenance programs is the application of the two principles of "equity" and "adequacy" in the construction and modification of specific benefit provisions These principles apply primarily to the formulation of policy in contributory programs, but, to some degree, they also are applicable to non-contributory and general pension programs Each of the old age programs in western European countries has wrestled with the conflict between these principles and the innumerable problems involved in combining or separating them in the same program

The concept of "equity" derives from private insurance, which has played an important role in influencing the evolution of "social" insurance This concept conceives of the individual's benefit as the annuity which would be purchasable on an ac [illegible]

[illegible] be incompatible with the fundamental purposes of social insurance, since it would preclude the payment of any except the most inconsequential benefits in the initial operation of the plan and also would result in too small benefits for the lowest paid workers

In some countries, such as the United States Germany, and France, "equity" considerations have loomed relatively large where individual responsibility has been stressed in a contributory program In Denmark, the Netherlands, and Sweden this element has been negligible in their plans, while in Great Britain it has played a moderate, but subordinate, role as compared with the United States, Germany, and France

All countries, however, are faced with the task of defining and redefining "adequacy" of benefits Some concept of "social adequacy" is explicitly or implicitly behind every old age benefit structure The objective may be to keep most persons off poor relief, to pay a "minimum subsistence," to provide a "basic floor of protection," or to provide a level of living compatible with a standard of "health and decency" There may be many other expressions of the objective They may vary from country to country and from time to time in a particular country This is one of the basic problems of an old age benefit program which is related to many social and economic factors, such as costs, incentives, cultural patterns, the standard of living of the economy, and the relationship to other institutional arrangements (private insurance, private pension plans, homeownership, and savings), to mention a few

Reinhard Hohaus (1948), vice president and actuary of the Metropolitan Life Insurance Company, was the first to point up the implications of these two principles in his stimulating article on "Equity, Adequacy and Related [illegible] curity' [illegible] of the [illegible] June, 1938 He showed that private insurance, being voluntary in character, must be built upon the equity between the various classes insured or that people would drop their insurance in one group for another Social insurance, on the other hand, being compulsory in character (as far as contributions are concerned), aims primarily at providing society with some protection against major hazards which are widespread and far reaching enough to become "social" in scope and complexion

Private insurance, then, tends to be adapted to the individual's need for, and his ability to afford, protection against a risk. Social insurance, on the other hand, tends to be molded to society's needs Both programs contain elements of individual and societal needs How both of these factors are combined and emphasized can change the program very substantially

provide for paying a basic benefit to all aged persons without an income or contribution test

In some European countries there is a national pension program but with an income test for part of the benefits These programs have some aspects of "assistance" *involved in them* (in the sense this term is used in the United States), but the income tests are on a more liberal and objective basis than "poor relief" and hence do not carry the same stigma as a "means test"

These varieties of universal pension plans combine various features, or principles, of different plans An analysis of the elements and trends in the evolution of these plans is essential to the understanding of the controversial issues involved in old age programs

Prior to 1935, European systems of old age security were considered to be of the "classic" social insurance type or the "classic" public assistance type As variations of each emerged, there appeared a kind of merging of insurance and assistance principles With the introduction of the term "social security" in the United States the expression gained universal currency to denote all varieties of plans and to cover the hybrid and universal types of plans evolving out of the early classical approaches

From the United States the term and the concept spread to New Zealand in 1938 and to other countries eventually culminating in an international social security convention adopted by the International Labor Conference in 1952

The tendency toward a blending of insurance and assistance programs in some plans was pointed out in an important document published by the International Labour Office in 1942 entitled *Approaches to Social Security* This report noted that the world wide experience had indicated that

> social assistance is a progression from poor relief in the direction of social insurance while social insurance is a progression from private insurance in the direction of social assistance
>
> If present day developments have been correctly read social assistance and social insurance are moving ever closer to each other As the culmination of a long evolution they may even meet and combine, until as in New Zealand and Denmark we can no longer say whether social assistance or social insurance predominates but only that they possess a national system of social security [pp 86-87]

In all European countries as in the United States social policy has been directed toward minimizing the extent to which older persons need to rely upon assistance Where the programs take income into account there has been pressure for liberalization of the income test so that the "assistance" features are minimized The effort to minimize the role of assistance was undertaken at the end of World War II as part of the effort of postwar reconstruction However, the inflation which developed made it impossible for the effort to succeed as fast as its proponents had hoped

In Great Britain, for example 72 per cent of all persons receiving national assistance as needy persons in December, 1956 were of pensionable age (65 for men and 60 for women) The overwhelming majority of these (90 per cent) were receiving assistance as a supplementation to their small insurance or pension payments Only 10 per cent of the aged on assistance were receiving no such insurance or pension payments The average allowance in supplementation of retirement pensions (15*s* 1*d*) in 1956 was approximately three-eighths of the normal retirement pension then 40 shillings a week (in 1959 it was 50 shillings a week) The problem of supplementing social security benefits in the United States by public assistance is a growing matter of concern The British experience indicates the importance of reviewing periodically the relationship between the benefit levels of both programs and the reasons for supplementation of the insurance benefit In Great Britain it appears that most supplementary payments are given to meet rent In the United States it appears that a growing proportion of

supplementary payments are given to meet nursing home and medical-care costs.

C Equity and Adequacy in Old Age Programs

One of the persistent problems in income-maintenance programs is the application of the two principles of "equity" and "adequacy" in the construction and modification of specific benefit provisions These principles apply primarily to the formulation of policy in contributory programs, but, to some degree, they also are applicable to non-contributory and general pension programs Each of the old age programs in western European countries has wrestled with the conflict between these principles and the innumerable problems involved in combining or separating them in the same program

The concept of "equity" derives from private insurance, which has played an important role in influencing the evolution of "social' insurance This concept conceives of the individual s benefit as the annuity which would be purchasable on an actuarial bas[illegible]

be incompatible with the fundamental purposes of social insurance since it would preclude the payment of any except the most inconsequential benefits in the initial operation of the plan and also would result in too small benefits for the lowest paid workers

In some countries, such as the United States Germany, and France, "equity' considerations have loomed relatively large where individual responsibility has been stressed in a contributory program In Denmark the Netherlands, and Sweden this element has been negligible in their plans, while in Great Britain it has played a moderate but subordinate role as compared with the United States, Germany, and France

All countries however, are faced with the task of defining and redefining "adequacy" of benefits Some concept of "social adequacy" is explicitly or implicitly behind every old age benefit structure The objective may be to keep most persons off poor relief, to pay a "minimum subsistence," to provide a "basic floor of protection," or to provide a level of living compatible with a standard of "health and decency" There may be many other expressions of the objective They may vary from country to country and from time to time in a particular country This is one of the basic problems of an old age benefit program which is related to many social and economic factors, such as costs, incentives, cultural patterns, the standard of living of the economy, and the relationship to other institutional arrangements (private insurance, private pension plans, homeownership, and savings), to mention a few

Reinhard Hohaus (1948), vice-president and actuary of the Metropolitan Life Insurance Company, was the first to point up the implications of these two principles in his stimulating article on "Equity, Adequacy and Related Factors in Old Age Security" published originally in the *Record* of the American Institute of Actuaries in June, 1938 He showed that private insurance, being voluntary in character, must be built upon the equity between the various classes insured or that people would drop their insurance in one group for another Social insurance, on the other hand, being compulsory in character (as far as contributions are concerned), aims primarily at providing society with some protection against major hazards which are widespread and far reaching enough to become "social" in scope and complexion

Private insurance, then, tends to be adapted to the individual s need for, and his ability to afford, protection against a risk. Social insurance, on the other hand, tends to be molded to society's needs Both programs contain elements of individual and societal needs How both of these factors are combined and emphasized can change the program very substantially

Different countries have blended elements of private and social insurance in various ways

Hohaus claims that society's need is for a "minimum of protection" and he thus introduces a controversial and changing element as to what is meant by "minimum" He concludes that "private insurance would collapse if it stressed considerations of adequacy more than those of equity, so will social insurance fail to remain undisturbed if considerations of equity are allowed to predominate over those of adequacy" He says that this "need not necessarily imply that all considerations of equity should be discarded from a social insurance plan rather the point is that, of the two principles, adequacy is the more essential and less dispensable"

What is meant by "equity" in social insurance is not a clear cut matter In private insurance the concept means that the individual's benefits are not less than the "value" of the contributions paid including any interest on any reserves minus administrative costs and taking into account mortality or other relevant factors But in social insurance it becomes difficult to determine this in view of compulsory employer contributions and direct or indirect subsidies Moreover, whether a standard of individual or group equity should be applied is open to differences of opinion Another view is that equity is attained if all who contribute the same amount receive the same in benefits while beneficiaries will argue that, if benefits are not related to length of contributions or amount of earnings a cardinal element of equity is violated

The generality of these two concepts makes them difficult to define in specific terms in a particular country The difference in the meaning of the concepts in different economic and cultural settings makes it impossible to compare their application in various countries Nevertheless the fact of the matter is that the issues raised by these concepts are inherent in the formulation and revision of old age benefit provisions In general the payment of a flat benefit is an illustration of a program which may have a high degree of "minimum social adequacy," while a program providing benefits and contributions related to previous wages may have a high degree of "equity" But programs of flat rate contributions and benefits may have a high degree of equity and also a high degree of minimum social adequacy (as, for example, Great Britain) Programs such as those in Scandinavia, Israel and New Zealand which have flat rate benefits but contributions fixed as a percentage of payroll are illustrative of programs with a relatively high degree of social adequacy and a minimum of individual equity

In Great Britain proposals for a wage related benefit program (which will be discussed later) indicate a movement away from a "minimum" concept of social adequacy to a higher level In the United States the original 1935 old age insurance law by relating benefits to total wages and postponing the effective date of benefit payments to 1942 stressed equity considerations The 1939 and 1950 amendments strengthened the "social adequacy" elements at the expense of "equity" considerations and also strengthened and preserved the wage related character of the program

In both Denmark and Sweden proposals for changing their programs to a wage related benefit program have been considered These proposals are still under consideration In Great Britain the government has made such a proposal

Undoubtedly tradition and the difficulties of changing over to a new approach have played some part in the discussions in Denmark and Sweden On the other hand there is strong pressure from labor groups in Great Britain and Sweden for a change to a wage related program It may be noted that the U S S R Czechoslovakia Poland and Yugoslavia have wage related programs and that the recent changes in West Germany are designed to strengthen and retain a wage related sys

tem in the face of inflationary tendencies and to meet the increases in wages productivity and the increasing level of living

No single simple conclusion can be drawn from the experience in western Europe as to the changing emphasis on equity and social adequacy Too many other factors come into play to make observations or decisions on only two elements in the equation One conjecture may be tentatively drawn from the experience both of western Europe and of the United States If productivity and hence the general level of living continue to rise then it will become necessary to re-examine the concept of social adequacy incorporated in the old age benefit program The minimum concept may rise as the level of living rises for the economy as a whole A decline in the standard of living through war inflation or population increases would raise still other issues Thus the question of social adequacy of the benefit amount and the scope of the program may be a changing one which each generation in each country will have to decide for itself in relation to many variables

D The Uniform versus the Wage related Benefit

A major issue which has resulted in basic differences in the way old age programs have operated in various European countries is whether the old age benefit should be uniform or wage related Expressed in general terms this may be stated as the question whether the old age benefit should be the same amount for everyone or whether it should vary for each person in relation to an individual s past earnings As will be shown there are several important variations on both of these general approaches However the broad policy questions and experience of different countries will be discussed first before indicating the modifications of each method which have developed over the years in the different systems

Old age benefit programs developed out of a concern by society for the large number of persons who became aged without any independent source of income Wages were low and it was difficult if not impossible for most individuals to save a sufficient amount for their old age Without some method of providing some regular income for aged persons there would be much social and political discontent

An old age benefit program involves however a matter of redistribution of income within any nation as among old and young the retired and the employed, and the higher income with the lower income receivers Thus a major matter of economic and social policy had to be decided as to how much income was to be redistributed and how This question thus touched on philosophical economic, social and humanitarian objectives

A major factor in this situation was the decision of Denmark in 1891 and Sweden in 1913 to utilize a uniform rate for old age payments and for Great Britain in 1911 to pay disability and unemployment benefits on a uniform basis irrespective of wage levels This same principle was embodied in the British *old* age insurance program of 1925 and has become a major distinguishing characteristic of the British programs for nearly 50 years Although now under cer [illegible]

[illegible] British Commonwealth countries and has exerted a major influence on many other programs throughout the world

The British approach of paying a uniform benefit each week was born in a period when wages were relatively low and wage differentials relatively narrow and when the objective of old age pensions was primarily to keep persons off poor relief of the Elizabethan poor law type Thus a uniform amount could meet this objective for a substantial proportion of persons. It was simple and understandable to large numbers of persons and relatively easy to administer in an era when business machines

and mechanized procedures for handling complex administrative matters were unknown But more basic than even these factors was the *egalitarian belief which in* part grew out of the socialist movement that all persons should be treated equally when in need Groups of workmen both in small groups in their local friendly societies and in their large national unions and political associations ardently advocated '*equal shares for all* as a method of sharing their scarcity There was no general recognition of a society in which productivity would be increasing wages would rise the standard of living would improve or inflation would be a *major factor* These elements did not begin to play any major role in reshaping social security policy in most countries until after World War I and only became a matter of general recognition after World War II

In an era of scarcity low wage levels and the influence of a strong socialist movement uniform benefits were rationalized as the most effective method of redistributing the available amount of income to the benefit of the lowest income *groups* *The public responsibility* for the aged was thus expressed in terms of achieving the maximum social result by assuring a basic minimum subsistence to the aged and leaving the individual free to supplement this meager amount from whatever other source he could The program thus developed was a unique blending of socialist and conservative philosophies to the effect that the best method of carrying out public responsibility with the minimum cost and the least interference with other important objectives of society was to have a uniform benefit for all aged persons

Several problems began to arise If a country wished to have an insurance or pension program with benefits related not to an individual s need but as a matter of statutory right *it seemed necessary to finance* a major share of the cost from payroll contributions If there was also to be a uniform benefit then it was only reasonable to have a uniform contribution irrespective of earnings In order that a uniform contribution would not be burdensome on the lowest wage earners it must *necessarily be geared to and limited by* the income of the low income receivers. Hence there was a very restricted limit to the amount which could be derived from the payroll contributions As the standard of living rose over the years if flat rate contributions were retained it was necessary either to raise the uniform contributions which would bear most heavily on the smallest earners to raise a larger proportion of the costs from other kinds of revenues to keep the level of old age bene*fits down or to employ some combination* of these three elements

This is the dilemma of uniform benefit programs In Great Britain serious consideration has been given to modification of their uniform benefit program The Trades Union Congress and the British Labour party reversed a long standing policy in 1957 by advocating building onto the uniform benefit program a supplemental wage related program (Labour Party 1957) The Conservative government in 1958 in*dorsed a system of graduated* contributions and benefits stating

> The earlier analysis of the present position brings out strikingly the limitations of a flat rate system The developing needs of the old in a community enjoying rising standards of life cannot be adequately met by contributions which have to be fixed at a level all can afford to pay The speed of the convoy is that of the slowest ship [Great Britain Ministry of Pensions and National Insurance 1958 p 9]

The British government s proposal *for* a graduated contributions and benefit program suggested April 1961 as a likely effective date The change in the British program if it takes place is a significant change which along with the changes made in the West German system in 1957 may *have important repercussions in* other European countries in the future [1]

[1] Both Great Britain and Sweden adopted graduated benefit systems in 1959 to be superimposed on their existing flat rate pensions

The conflict over changing the Swedish system to a graduated program has resulted in major political differences in that country. Efforts to change the Swedish pension program resulted in the fall of the government in 1958.

The Social Democrats proposed a system of supplementary wage related benefits in 1958 on top of the uniform basic benefits. The total benefit—basic plus supplementary—would amount to about 65 per cent of the individual's average income during his 15 best income years. The cost of the supplementary benefit was to be met entirely by the employer. The supplementary benefits would be automatically increased in relation to the price index.

An advisory referendum on supplementary pension was undertaken at a national election in 1957. The results were 46 per cent for the Social Democrat proposal described above, 35 per cent for voluntary supplementary pensions established by collective or individual measures and supported by the Conservatives, Liberals, and employers, and 15 per cent for a voluntary plan, administered by the government, and [illegible]

[illegible]

many different policy questions involved in developing a graduated program. To what extent should contributions for old age be compulsory? Who should contribute? How much? What effect will these decisions have on wages and the total economy?

The decision in 1935 in the United States to incorporate the wage-related principle in the old age insurance program was a vital one. As private pension plans spread, it becomes more difficult to change from a uniform program to a graduated one. The decision in the United States came at a time when there were relatively few private pension plans, and, hence, the policy and technical problems were not so difficult as they are now in western European countries.

E. Adjustments to Increases in the Cost of Living

A major problem for all kinds of old age programs occurs when prices increase, especially when they increase rapidly in a short period of time.

An increase in prices acts to decrease the value of fixed social security benefits. Individuals who are on fixed incomes feel the effect adversely. In order to adjust the benefit structure to rising prices, many social security programs have periodically raised the basic benefit level or added special cost-of-living supplements. In countries with flat benefit structures, such as Great Britain and some of the Scandinavian countries, the increase in the benefit did not change the basic characteristics of the system. In those systems where benefits are related to wage level and length of contribution, the minimum benefits were increased (Italy and Belgium). This tends to modify the basic philosophy of the wage-related system by limiting the spread in benefits and thus tending toward the flat rate systems.

Inflation causes serious problems for all types of systems whether they are insurance [illegible]

[illegible] portant factor, of course, is that it injects new financial considerations into the program at a time when the government is having other financial difficulties. Inflation may result in a temporary or permanent increase in income to the old age system which collects contributions in relation to wages, employment, or income. This increase in income may be used, in part, as a supporting argument by those groups appealing for an increase in benefits. Where the system has some reserves, the existence of such reserves may be used by some persons as another argument for such an increase. But any increase in benefits necessitates considering long run costs and financing methods to meet such costs.

The net effect of these and other factors

is to delay government action so that there is a lag in adjusting benefit payments to the rise in the cost of living. To overcome this, some countries, such as Denmark, Iceland, and the Netherlands, introduced automatic adjustments in the benefits to the cost of living. Despite the obvious advantages of this approach to the beneficiary, it has not received universal acceptance because of other considerations.

F. Adjustments to Changing Wage Levels and Productivity

In considering recent proposals and changes in old age benefit levels, two types of adjustments must be clearly distinguished. First is the adjustment to changes in prices. This is usually an adjustment to changes in the cost of living. Second is the adjustment to changes in wage levels. This is usually an adjustment to changes occurring both in the price level and in the productivity of the economy. These two adjustments both can be incorporated into the same program or can be separated.

Reference has already been made to countries which have incorporated a cost-of-living adjustment in their benefit structure. Despite inflation, it is significant that only a limited number of countries have included such an automatic adjustment in their laws, preferring an *ad hoc* arrangement for determining the necessary benefit and financial changes necessary as conditions warrant and by the normal processes of parliamentary debate.

The adjustment to changing wage and productivity levels is of recent origin. As best as can be determined, the idea of such an adjustment first was proposed in Sweden (Sweden, Pension Committee, 1950). Although the proposal was not accepted in Sweden, it was adopted by Germany in 1957 and has been included in the British Labour party's proposal of 1957.

Actually, the mathematical basis for such an adjustment is not complex in principle. The earnings of each individual are related to the average earnings of all persons each year. Then these indexes are averaged over a person's entire lifetime, so that his relative rank in relation to all persons would be determined. The level of earnings at the time the individual claims his benefit, along with the number of his years of coverage, would determine the individual's monetary amount of benefit. Adjustments after retirement would also be made on the basis of changes in earnings levels.

The system in the Federal Republic of Germany was basically modified in 1957. One of the more important changes made was the introduction of an automatic adjustment to reflect changes in past wage levels. This very much paralleled the proposal that had been considered in Sweden, except that the German basis goes much further because it relates not merely to future contributory coverage but also to the very extensive coverage that has existed for many decades in the past. In fact, the German system has been in operation for so many years that the working lifetime of virtually all retired persons in the population has been within the period when contribution records were maintained.

For those retiring in the future under the German system, the contribution record of all past years will be adjusted on the relative basis previously described. The benefit will then be determined from the years of coverage, the relative rank of the individual's earnings, and the current average wage at time of retirement. The current average wage is computed as the average of the first three of the four years preceding the year of retirement. Those currently retired had their benefits adjusted by a conversion table, after adoption of the law, so as to yield approximately the same result as though individual recomputation on the same basis as for future retirants had been made. There had been considerable debate as to whether benefits in force should be automatically, and more or less continually, adjusted in the future in case of further inflation and, also, if this were done, whether the adjustment should be on the basis of changes in

price level or on the basis of changes in earnings level The latter basis it is to be recognized would usually produce a greater increase since wages tend to keep pace with inflation and further rise with improved productivity even if there were not continued inflation The final law, however, does not contain any provisions for automatic adjustment of benefits in force but provides only for study of the system s financial position and of trends in productivity and earnings Based upon recommendations made by an expert advisory council the German Parliament increased benefits effective January 1 1959 on the basis of employment and productivity gains since 1957 (U S Department of Health Education and Welfare 1959)

The Netherlands has also adopted an automatic adjustment feature in its universal old age pension plan that was established in 1956 to replace a temporary plan that had been adopted shortly after the war Since this program provides flat benefits it is relatively easy at appropriate intervals to apply changes in the cost-of living index to the benefit rate In actuality between the time that the legislation was enacted and payment of the first benefits the cost of living changed sufficiently to result in a higher rate of benefit than had originally been anticipated The financing of the plan is achieved through a tax on wages and earnings and this is geared in with inflationary conditions since the maximum taxable limit is similarly adjusted for changes in the cost of living

Denmark too has adopted a plan involving a minimum pension payable irrespective of income or means which is to be adjusted for changes in the cost of living index just as is the so-called national pension which depends on the income of the individual A somewhat related development in Denmark is the new provision for inflation proof annuity contracts purchasable from insurance companies or banks. These are designed to supplement the social security benefits and so are available in only limited amounts The premium rate is to be adjusted for changes in the cost of living index and likewise the eventual annuity payments are so adjusted Obviously, if there is a rise in the cost of living part of the higher annuity payable will be met by the increased premiums paid The remaining portion of the annuity, including any adjustments after entering on receipt of annuity will come from the government Of course in no event will the annuity be less than that purchasable from the premiums paid

A number of other countries that have been plagued by inflation are apparently thinking of installing some automatic built in device in their social security system to compensate for this factor For instance in Great Britain the Labour party's proposal is for a general contributory plan to be added on top of the existing flat benefit system In the contributory portion the same general basis of automatically allowing for changes in the earnings level would be

setting inflation in the case of an earnings related benefit program is to base the pension on the average salary during the last few years (5 or 10 years) before retirement This approach is used by many private pension plans in the United States. This procedure may be subject to greater chances of unusual results because of ignoring most of the individual s working history It also does nothing about changes in economic conditions following retirement Nonetheless perhaps because of its greater simplicity it is being widely adopted or considered by many countries

Ad hoc methods still remain popular in many countries Thus in the United States benefits were increased on the average 77½ per cent in 1950 by approximately 15 per cent in 1952 by about 12 per cent in 1954 and by 7 per cent in 1958 In Belgium France and Italy benefits have been raised by increasing the value of earnings or contributions made in early years when wages

were less *Ad hoc* methods have the advantage of being adaptable to the situation. For instance, when a certain degree of inflation occurs and some changes are possible in part due to the prospects of increased income, the legislators can take a new look at both the benefits and the financing of the system. It can then be decided by the elected representatives of the people whether benefits should be adjusted in amount or whether the available money

TABLE 1*

PENSIONABLE AGES FOR NORMAL BENEFIT UNDER GENERAL OLD AGE PROGRAMS IN EUROPE, BY COUNTRY, 1958

Country	Men	Women
Albania	60	55
Austria	65	60
Belgium	65	60
Bulgaria	60	55
Czechoslovakia	60	55
Denmark†	65–67	60–62
Finland‡	65	65–63
France	60	60
Germany—East	65	60
Germany—West	65	60
Great Britain	65	60
Greece	65	60
Hungary	60	55
Iceland	67	67
Ireland	70	70
Italy	60	55
Luxembourg	65	65
Netherlands	65	65
Norway	70	70
Poland	65	60
Portugal	65	65
Rumania	60	55
Spain	65	65
Sweden	67	67
Switzerland§	65	63–60
Turkey	60	60
U S S R	60	55
Yugoslavia	55	50

[illegible]

† For the minimum pension in Denmark, the age is 67 with [illegible] income test. For the national pension and [illegible]

[illegible] 63

§ Women workers eligible at age 63 wives at age 60

should be used to finance new types of benefits. This is of special importance when the system is still in the process of development. From a purely political standpoint, under *ad hoc* arrangements, the legislators or administration at the time would get the credit for any changes—rather than those who originally developed the cost-of-living or other economic indexes This consideration might be less significant in parliamentary forms of government where the legislative and executive branches are under the same control.

III. RETIREMENT CONDITIONS

Among the important conditions affecting an old age program are: (1) the age or ages at which benefits are payable to aged persons; (2) whether receipt of benefits is subject to a test of retirement, and, if so, what kind of test; (3) whether benefits are increased for delayed retirement, and, if so, by how much; and (4) whether benefits are reduced for early retirement, and, if so, by how much. These conditions affect the social adequacy of the benefits payable, the cost of the program, and other provisions of the plan Experience of European countries with these provisions is discussed in the following pages

A Retirement Age

Retirement ages vary substantially among the twenty-eight European old age programs A spread of 20 years exists between the highest and lowest retirement ages provided under general programs in Europe The spread is 15 years for men and 20 years for women

In ten countries the age is the same for men and women. A majority of the countries, totaling eighteen, provide a differential age for men and women In Europe the differentials for women, where they exist, are usually 5 years below that for men in all but two countries.

Table 1 indicates that the highest retirement age is 70 and that the lowest is 50 for women and 55 for men The infor-

mation from this table may be summarized as follows

Four countries have a retirement age of more than 65 years for both men and women two countries (Ireland and Norway) specify age 70 for all persons, and two (Iceland and Sweden) specify age 67 for all persons

Four countries (Luxembourg, the Netherlands, Portugal, and Spain) have a uniform age of 65 years for both men and women Thus a standard age of 65 for both men and women, which was in effect in the United States during the years 1935–56, is not the most typical in Europe at the present time

A dual pensionable age of 65 for men and 60 for women is prescribed in eight countries (Austria, Belgium, Denmark, East Germany, West Germany, Great Britain, Greece, and Poland)

Two countries with age 65 for men have differential ages for women One country (Finland) has 65 for men, and the assistance portion may be paid at age 63 for women In Switzerland women workers become eligible at age 63, if the wife is age 60 the couple's pension is payable No country in Europe (and no other in the world) has the 65 for men and 62 for women (full benefits for widows and an actuarially reduced benefit for other women) which is now in effect in the United States

In the ten remaining countries, a uniform age of 60 is provided in two (France and Turkey), in seven (Albania, Bulgaria, Czechoslovakia, Hungary, Italy, Rumania, and Russia) a dual pensionable age of 60 for men and 55 for women is specified, and one (Yugoslavia) has 55 for men and 50 for women The information classified separately for age by sex for the twenty-eight European countries, as of 1958 is shown in Table 2 Thus the "median" pensionable age may be said to be 65 for men and 60 for women

In the course of many years of experience some countries have lowered their pensionable ages, and a few others have increased them. While it is not possible to generalize about whether there currently is a definite trend upward or downward, it is clear that there has been a review of the pensionable age in many countries, and it appears that this is likely to spread to other countries

The four countries with an age requirement above 65 have not altered it since it was first adopted Ireland has maintained age 70 since 1908, Norway, age 70 since 1923, Iceland, age 67 since 1909, and Sweden, age 67 since 1913 An Irish White Paper in 1949 proposed lowering the age

TABLE 2*

PENSIONABLE AGE FOR NORMAL BENEFIT UNDER GENERAL OLD AGE PROGRAMS IN EUROPE SUMMARIZED BY AGE AND SEX, 1958

Retirement Age	Men	Women
70	2	2
67	2	2
65	14	4
63		1
60	9	11
55	1	7
50		1

* *Source* Derived from Table 1 The ages tabulated for women were Denmark, 60 Finland, 63 and Switzerland, 60

to 65 for men and 60 for women as part of introducing a contributory plan This was not adopted in the new Irish Act of 1952, although the legislation did provide that insured workers who had paid 156 weekly contributions *may* receive unemployment benefits so long as they are unemployed, without limit as to duration, between the ages of 65 and 70 Sweden has studied on various occasions, the possibility of reducing its 67 year age limit but has decided against it because of the cost involved as a result of its unusually large aged population

Great Britain began with a uniform age limit of 70 in 1908 in its non-contributory program and reduced the age to 65 when contributory insurance was introduced in

1925 In 1940 the age for women was reduced to 60 In 1954 an advisory committee (the Phillips Report) recommended (with the two trade unionists dissenting) that the pension age should be raised from 65 to 68 for men and from 60 to 63 for women It was proposed that legislation should provide for an increase of 1 year in a period of not less than 5 years, with further increases of a year at a time at later intervals No action was taken by the government on this recommendation (Great Britain, Phillips Committee, 1954)

In 1957 the British Labour party and the Trades Union Congress advocated a basic change in the British flat rate contributions and benefit program A wage related program was proposed No modification was recommended in the age of 65 for men Because women draw a flat rate pension at age 60 no change was suggested for this payment, but, to receive the full basic National Superannuation pension age 65 was proposed for women also (British Labour Party, 1957)

The original German law of 1889 provided pensions only after age 70 The German program was initially principally an invalidity insurance plan and its old age provisions were essentially supplemental in character Old age pensions were smaller than invalidity pensions and were payable only to persons over 70 who could not prove that they were invalids There was much pressure to lower the age from the start but the cost seemed too great The government later found that its actuarial estimates considerably overstated costs and in 1916 it reduced the age to 65 bringing it in line with the retirement age fixed in 1911 in a separate program for salaried employees

After World War II, East Germany adopted a sex differential of 65 for men and 60 for women In 1957 West Germany adopted its new dynamic pension program and along with many other changes provided that a woman may draw her pension at age 60 if she has worked in covered employment for at least 10 of the 20 years prior to retirement A provision formerly applicable only to salaried employees was also extended to wage-earners at age 60 an insured person becomes entitled to a pension if he has been unemployed a full year

The Danish experience differs from that of both Great Britain and Germany Danish non contributory pensions began in 1891 with a uniform pensionable age of 60 In 1922 the age for men was raised to 65, although discretion was given to pay pensions to men at age 60 in exceptional cases where failing health or other special circumstances warranted In 1948 the Danish government set up a special advisory commission to report on whether to replace the non-contributory program with a pension plan The commission reported in 1955 and while recommending against establishment of an insurance plan did recommend that the pension age be increased to 66 for men and 61 for women They proposed that the age be increased from 65 for men and 60 for women in two step ups of ½ year (that is to 65½ and 60½ and to 66 and 61) in 2 year intervals In the important revisions of 1956 a minimum pension was established for which age 67 is required No minimum contributions and no income test are required for this For the national pension and supplements (both subject to an income test) the age beginning in April 1961 will be 67 for men and 62 for women The ages will be 66 and 61 respectively from April 1959 to March 1961

Denmark is thus the only European country (and one of only three or four countries in the world) which has raised its pension age since it first established an old age program Whereas in the original law of 1891 the age was 60 for both men and women by 1961 the age is scheduled to be 67 for men and 62 for women

B Retirement Test

Several European countries like the United States provide for payment of the

old age benefit only upon "retirement" from gainful work. Other countries provide for payment of a "pension" upon attainment of pensionable age, irrespective of retirement. It should be kept in mind that the term "pension" is not used in either the "insurance" or the "assistance" programs in the United States. This was a deliberate attempt by those who formulated the original Social Security Act to sharply distinguish these programs from the European models as well as from veterans' "pensions" in the United States which are paid entirely out of general federal revenues.

In comparing plans which have retirement provisions with those which do not, the level of benefits, the retirement age, and the type of program (whether insurance or assistance) must be considered, in addition to wage and employment conditions in the country. It is not possible, therefore, to evaluate by itself the effect of a retirement test on the old age program or the economy.

In Great Britain the question of the retirement test has been discussed and debated in recent years. The contributory pens on [illegible]

they reached pensionable age, irrespective of whether they were working or not. The old age benefit was then a relatively small uniform amount. In 1946, based upon the recommendations of the Beveridge Report, pension payments were made conditional on retirement from work, for the 5 years between ages 65 and 70 for men and 60 to 65 for women, and provision was made for increasing the pension by adding delayed retirement credits for persons continuing to work after reaching the minimum pensionable age. At age 70 for men, and 65 for women, the benefits are paid irrespective of retirement.

Beveridge analyzed the problem as he saw it in 1942 as follows:

> Pensions adequate for subsistence without other means should be given only to people who, after reaching a minimum age for retirement, have in fact retired from work. To give a full subsistence income to every citizen on his or her reaching the age of 65 or 60 would impose an unjustifiable and harmful burden on all citizens below that age.
>
> Making receipt of pensions conditional on retirement is not intended to encourage or hasten retirement. . . . To attempt to force people to retire before their powers and desire for work fail, and to compel them by a rise in the minimum age of pensions to struggle on after their powers have failed, are two errors and injustices which should be avoided by any system of social insurance designed to increase human happiness. [pars. 244–45]

The British retirement test differs in a number of important respects from that of the United States. In the first place, the British attempt to enforce bona fide retirement by requiring the individual to show he has retired from regular employment. Those persons who intend to do some work after retirement are treated as retired if the work is only occasional, inconsiderable in extent, or otherwise not inconsistent with retirement. Rather elaborate and technical rules have been established to define these terms. An independent adjudicating authority decides individual cases—initially by an insurance officer—with a right to appeal to a local tribunal and ultimately to the national insurance commissioner.

Discussion on the retirement test in Great Britain now centers around its application in any national superannuation plan with wage related contributions and benefits. It is estimated that abolition of a retirement test in such a plan would increase the cost about three-quarters of 1 per cent of payroll. In general, the same questions of financial costs and social priorities and needs which have been the decisive elements in retaining the retirement test in the United States are being considered in Great Britain.

Conditions of employment and related economic and social factors are so different

in the various European countries, and the provisions of the old age programs so diverse, that it is not possible to summarize here or to generalize about the retirement test or its absence from European programs Almost every variety of provision can be found among the European countries

C Delayed Retirement Credits

Available information indicates that in 1958 eleven European countries had some type of provision which increases the old age benefit when the beneficiary delays his retirement past the normal or minimum pensionable age These countries are Bulgaria, Czechoslovakia, Denmark, Finland, France, Great Britain, Iceland Italy, Turkey, the U S S R , and Yugoslavia

Finland, Iceland and Great Britain are illustrations where the uniform benefit is increased France, Italy, and Turkey have wage related systems in which the benefit is increased for delayed retirement The rate of increase in the uniform benefit programs is as high as 12 5 per cent of the benefit for each year of delay in Finland (for the basic pension), 7 5 per cent in Iceland, and 6 per cent in Great Britain In the wage related programs the increase is 4 per cent of wages in France and 1 per cent of wages in Turkey In France, for instance, the benefit attainable at age 60 increases from 20 per cent of wages at age 60 to a maximum of 40 per cent of wages at age 65

A delayed retirement credit provision is usually justified on the grounds that it encourages employment, reduces the cost of retirement to the program or to the nation or is equitable to the contributor or beneficiary

Experience in Great Britain and New Zealand seems to indicate that the financial inducement involved in a delayed retirement credit does not have any appreciable effect on postponing retirement Failing health or strength usually are the determining factors in early retirement, and compulsory retirement in a firm usually determines the particular retirement age for many persons It is not possible to evaluate the psychological effect which delayed retirement provisions have on encouraging older persons to work The level of benefits and many other factors undoubtedly play a significant role

If the delayed retirement credit is made equal to the actuarial saving due to the postponement of benefits, there is of course, no net saving to the old age program Thus in the United States it is estimated by Robert J Myers, the chief actuary of the Social Security Administration that a delayed retirement credit of about 8–10 per cent of the benefit for each year of postponement would be equivalent to the actuarial saving But this would mean an increase in cost to the program of over 1 per cent of payroll, which is equivalent to close to $2 billion annually

There are some who advocate repeal of the retirement test, or introduction of a delayed retirement credit on the grounds it would benefit the nation and the individual to continue working This involves an analysis of both general economic conditions and the implications of employment for older persons in a work centered society It should be noted that this argument tends to be advanced vigorously when economic conditions are good and is of less currency in a period when economic conditions are adverse or are declining

The argument that a delayed retirement credit is necessary to assure "equity" to the contributor or beneficiary may be more frequently heard when the old age program is financed with payroll or earmarked taxes on the contributor However the relevance of the argument may depend upon other factors in the financial and benefit structure such as whether the benefit payable to the individual already is in excess of the value of his own contributions and the "adequacy" of the benefits Those who oppose the delayed retirement credit however, point out that, from an adequacy standpoint, the amount needed by a bene

ficiary does not depend upon the age of retirement.

In Britain the delayed retirement credit was subject to review by an advisory committee in 1956 (Great Britain National Insurance Advisory Committee 1956) Current data on its operation are reported by the Ministry of Pensions and National Insurance in its annual reports In general, it may be noted that the provision has its supporters and opponents There is a general recognition of the practical difficulty involved in eliminating it even by those who wish to use the savings for other improvements in the old age program which have a higher social priority Thus as in many other provisions in an old age benefit program social philosophy and costs, incentives and psychology merge together in the consideration of alternatives and it becomes difficult to make a decision on the basis of one factor alone

D A Flexible Retirement Program

Some old age benefit programs provide that benefits may be paid to an individual prior to his normal retirement age if he takes a reduction in his benefit Others provide as we have seen for the increase in the benefit if the individual postpones retirement after the normal retirement age Practically every old age benefit program now provides for the payment of benefits to persons disabled prior to the normal retirement age

These three provisions may be said to produce a condition of flexibility in a retirement program Costs social philosophy and administrative feasibility appear to influence the decision as to such conditions

E Disability Insurance

One of the areas in which European experience and *materials* have made an important contribution to social security in the United States is with respect to the concepts in the formulation of disability insurance and the methods of administering it.

Disability payments, as part of a social insurance program, developed earlier and more extensively in Europe than in the United States While in the United States some experience was derived from workmen's compensation occupational pension and disability plans and veterans' disability programs, in the formulation of a general disability insurance program, definitions and administrative experience in the disability provisions of social insurance were readily transferable from Europe to the United States Although there are important exceptions to a categorical statement, the disability insurance provisions of the social security program and the comparable major provisions of European programs perhaps are closer, on the whole, in their principles concepts, and administration than with respect to old age programs, which are more varied

A basic document on disability insurance in the United States, *Disability among Gainfully Occupied Persons* published by the Social Security Board in 1945, relied heavily on European experience A comparative analysis of the permanent disability insurance provisions in six selected European countries (Czechoslovakia, France, Germany, Great Britain Italy and Sweden) was tabulated for 1939

The relevance of European experience was a major factor in the controversy over whether disability insurance should be added to the social security system The minority view (two members) of the Advisory Council on Social Security to the Senate Committee on Finance in 1948, which opposed disability insurance as part of the social security program stated

> It is sometimes claimed that other countries have blazed the way for the successful inclusion of total disability in a governmental contributory social insurance program This type of coverage originated in central Europe To cite Germany and Austria as examples which we should now emulate will not carry conviction in the United States [U S Congress, 1949 p 89]

IV Attitudes toward Pension Provisions

As indicated previously, the pensionable age and level of benefits varies widely among European countries To what extent this accurately reflects the attitudes of persons in different countries is not known

In 1958, "World Poll," conducted by International Research Associates, asked persons in several countries concerning their views on two issues affecting older persons The first question dealt with "the right age for retirement for a man" The replies showed that the average retirement age preferred in the six European countries ranged from 66 3 years in Great Britain and Denmark to 57 1 years in France In Sweden the average was 64 2 years Germany, 63 4, the Netherlands 62 5 and Italy, 60 8

TABLE 3

Opinions on Adequacy of Benefit Levels in Old Age Programs in Seven Countries 1958*

(Per Cent)

Country	Too High	Too Low	About Right	Don t Know	Total
Great Britain	1	71	26	2	100
Denmark	3	47	46	4	100
Sweden	5	47	46	2	100
Germany	2	48	37	13	100
Netherlands	1	64	30	5	100
Italy	1	76	16	7	100
France	†	87	6	7	100

* Source New York Herald Tribune October 11 12 1958
† Less than 0 5 per cent

Another question asked was "From what you know about the system of government old age benefits in your country do you feel that these benefits are too high too low, or about right? The results of the poll on this question are shown in Table 3

Several observations may be made from these results In the northern European countries there is reasonably good agreement that the appropriate age for a man to retire is about 65 In the southern European countries (Italy and France) the appropriate age is lower These results probably stem in part from the fact that the current age for pensions corresponds closely with the attitudes expressed Current practice apparently influences attitudes as well as vice versa

It also appears that practically no one in any of the countries polled considers payments to the aged too high While a substantial proportion think the level of payments is about right there is a larger proportion in every country who believe payments are too low

V Economic and Financial Aspects

The economic and financial aspects of providing income to aged persons raises many large and controversial issues Illustrations can be taken from the European experience to document any of a number of conflicting positions which are recurrently debated Advocates and opponents of specific policies in the United States have frequently quoted European experience in their behalf—both "successful and unsuccessful experience

Are payments to the aged a "burden on the economy? Are reserves necessary or desirable in old age insurance? Are private pension plans desirable? Who should bear the costs of pensions? What effect do pension programs have on investments incentives and the general progress of the economy? These are some of the basic questions which are common to all countries with old age programs

A Costs of Old Age Security

Over the course of many years there has been widespread interest in the costs and the so-called burden of providing for the aged A number of financial studies have been made on the expenditures for social security or for social services and for public expenditures for the aged All these studies have many deficiencies although they can be used for limited specific purposes However, when attempting to make international comparisons it is necessary

to have the total income and expenditures (public and private) on behalf of the aged, since there are different divisions of public and private responsibility for the aged in different countries For instance, the growth of private retirement plans in several countries makes any analysis limited to public expenditures of very limited use Moreover, the question of including or excluding disability, veterans', and public employee programs (and excluding survivors' benefits) makes international comparisons very difficult

[illegible]

lished some general estimates for the United States for 1951 Brian Abel Smith has made estimates for the United Kingdom *for 1954 These* estimates are of interest in showing the kinds of data which are necessary if more reliable international comparisons are to be made in the future

The costs of a particular old age plan depend upon the level and scope of benefits and the maturity of the program In most cases as old age benefit programs mature the costs increase Thus a comparison of plans in different countries which are in different stages of development is of limited value

Although the old age insurance system in the United States is 25 years old it is still in the early stages of development Present day costs are below those which will eventually evolve as the program matures and the number of beneficiaries increase Costs may also increase as the level and scope of benefits change although relative costs may be stabilized or decline if the gross national product continues to increase

The long run cost of the Old Age, Survivors and Disability Insurance system in the United States was estimated in 1958 to cost about 8½ per cent of payroll on a "level premium intermediate cost basis. This was based upon cost estimates issued in 1958 for the law as last amended in 1958 (Myers 1958b)

Another difficulty involved in making comparisons of the costs of European plans is that frequently financing of old age is tied together with other social security programs in a co-ordinated financing arrangement Finally, in countries with reserves interest earnings may yield a substantial income

These factors should also be kept in mind whenever comparisons are made Too frequently, cost comparisons between European and United States programs have been made without due regard to these limitations and differences

Obviously, old age programs cost money And different countries have different ideas as to how these funds can best be raised The concepts of equity and adequacy of financing and benefits vary with different countries. There is *no single formula* to appraise these differences or developments Despite the material produced in recent years on the financing of old age programs in various countries, it is impossible as yet, to make a valid comparison of different programs in different stages of evolution Much more technical work needs to be done to make some progress in this area

B Sources of Funds

Policy decisions with respect to financing old age benefits have had an important bearing on policies with respect to the type and adequacy of benefits provided Decisions as to benefits and contributions are usually tied together

A number of the old age benefit programs in Europe are financed on a tripartite basis, that is, with contributions from employers, employees, and the government The general programs in Austria, Belgium Germany, Great Britain Italy, Switzerland and some of the smaller countries follow the "classical" tripartite financing basis In this respect the program in the United States differs from these programs in Europe

The European programs were originally enacted as a part of the political and social movement, at the turn of the century to

overcome the poverty which existed The low wages of many persons made it difficult to assess the full cost on employers and employees Hence governmental contributions were necessary to inaugurate the systems

In addition, it was not possible to pay full benefits to older persons who had not contributed for their entire working lifetime, unless the employer or the government made up the deficit Hence a governmental subsidy was adopted to mitigate the financial impact on the employer and the employee of the so called "accrued liability" for past service on which no contributions had been collected

The system in the United States is not only self supporting from employer and employee contributions (plus the interest earnings from the Trust Fund), without any general government subsidy, but it also provides for equal contributions from employers and employees

In Albania, Bulgaria, Czechoslovakia, Poland, Rumania, Yugoslavia, and the U S S R, no employee contributions are payable These programs all have been modeled after those in the U S S R In Hungary there is an employee contribution for old age pensions—as distinct from invalidity and survivors' insurance There are no payroll contributions in Ireland, since old age payments are on an assistance basis only

In countries where both employers and employees contribute, their respective contributions are not always equal In a number of countries the employers' contributions amount to a larger proportion than those of the insured individual This is the case in France, Greece, Italy, Portugal and Turkey In one country, Iceland, the individual pays a larger share of the contribution than the employer—in fact, more than double the latter

There are several other varieties of financial arrangements In a few countries the financing is primarily through subsidies, or earmarked income taxes This is the case in Denmark, Finland, and Sweden In Greece, Portugal, and Turkey, and in some of the other European countries there is no subsidy from public sources France pays pensioners with low incomes a special subsidy financed by earmarked taxes In Ireland the total cost is met from governmental funds In the United States, while there is no subsidy from public sources to the insurance program, the federal government makes a substantial financial contribution to the states for old age assistance

C Private Pension Plans

Private pension plans have existed in countries like Denmark, Great Britain Norway, Sweden, and Switzerland for more than 50 years Undoubtedly, there are private pension plans in other European countries, but no comprehensive report for all European countries on this aspect appears to have been made Existing information relates to programs in Denmark Norway, Sweden and Switzerland as of 1952 and to Australia and New Zealand as of 1951 (Anonymous, 1953) A recent survey by the Government Actuary (1958) in Great Britain presents information on British developments

In general, the same policy questions arising out of the existence of private pension plans appear to exist in European countries as in the United States The lack in many plans of 'vesting provisions' (preserving the accrued rights of employees who quit) which tends to inhibit mobility of labor has raised serious questions as to the desirability of having "portable pensions" in Great Britain Likewise, the existence and rapid growth of private plans have stimulated vigorous opposition to increases in the benefit level as proposed in the recent plan of the British Labour party for the governmental system

Another important policy question has been whether private plans which have benefits equal to, or better than, that required by a governmental plan *should be permitted* to be exempt from or to 'contract out'

of the general public system. This issue was current in Great Britain in 1957–58, where interestingly enough both the Labour party and the conservative government are recommending such a policy with respect to the graduated wage related benefits above the basic minimum (50s) This same policy was urged in 1935 in the United States by some insurance companies but after extended discussion was dropped by Congress and its insurance company sponsors Actually such a proposal was adopted by the United States Senate (the Clark Amendment) but was not incorporated in the final Social Security Act of 1935 Insurance companies in the United States have not favored ' contracting out in the old age benefit program since 1935 (Clark 1959)

In general it may be said that the sponsors of private pension plans in Great Britain and the United States tend to favor an old age benefit limited to provision for "basic needs in retirement On the other hand because private pension plans tend to cover the higher income-earners and do not cover all employed persons or the self-employed there is still pressure for improving the adequacy of the benefits for the public system for those not covered by private plans Hence the conflict between the advocates of the two types of plans persists The controversy tends to place employers and insurance companies on one side of the argument and the labor unions on the other side The actuarial technical and policy problems thus tend to be transferred into the political arena because of the basic ideological differences as to the role of private and public responsibilities for providing income to the aged

VI Social Security Provisions and Rehabilitation of Older Persons

One of the significant developments in recent years in both Europe and the United States is the development of rehabilitation programs and their relationship to social insurance and social assistance programs In the United States, rehabilitation measures have been developed in relation to workmen s compensation disability insurance, and public assistance To some extent, rehabilitation has been applied to older workers, but this has been primarily, where the individual is physically disabled and has potentialities for being vocationally rehabilitated

Existing legislation in the United States, as in Europe, appears to encourage closer working relationships among income-maintenance programs health services, and vocational rehabilitation In a number of countries with comprehensive social security programs which include health benefits the vocational rehabilitation service is part of the over all program or closely integrated, financially or administratively, with the social security system

This problem of the extent to which vocational rehabilitation should be tied into the existing social security system presents

the employment service, and pensions or should it be independent? Should it be financed from social insurance contributions, general revenues or both? Should rehabilitation have both a vocational and a social objective and if so should they be administered together or separately?

These kinds of issues and problems are highlighted in the United States by the 1954 vocational rehabilitation amendments and the 1956 disability insurance and public assistance amendments and other proposals being considered While the Office of Vocational Rehabilitation, at the federal level is in the Department of Health, Education and Welfare along with medical care education and welfare services, at the state level it is tied in primarily with state departments of education This is the result of the historical evolution of rehabilitation services growing out of the World War I interest in vocational education and retraining of veterans The existing admin-

istrative relationship is distinctly an American phenomenon and differs sharply from the European experience

Vocational training of handicapped persons was initiated in Europe and the United States before modern medical rehabilitation began to develop The inadequacy of measures to eliminate or reduce the disability before the provision of vocational services frequently led to training around the disability Expensive and time-consuming vocational training was given handicapped persons who either were unable because of their disability to take full advantage of the training or who would not have needed it had medical rehabilitation and selective placement been available This emphasis on vocational training resulted in many countries in a limited program that was not properly balanced with respect to the wide variety of services needed in an effective rehabilitation plan The medical and vocational programs were frequently run as separate services with very limited co ordination The problem of administrative location financing and organizational relationships thus becomes part of larger issues dealing with the philosophy orientation and scope of rehabilitation services generally

The current concept of rehabilitation as a process aimed at maximum adjustment of the handicapped from the point of view of his total needs as an individual has helped to bring the various services into closer co operation in many countries Vocational rehabilitation is no longer considered a separate service concerned only with the vocational problems as such but rather as an integral part of a broader program of total rehabilitation Efforts are being made in many countries to integrate the vocational services with medical psychological educational economic and social assistance in order to facilitate the development of a well co ordinated rehabilitation service and to avoid a piecemeal approach to the task The various professions which in the past worked more or less in isolation are thus linked up to make for teamwork in the solution of the various problems caused by the disability These developments have been instrumental in promoting vocational rehabilitation programs in which services are provided as part of a continuous process eliminating or at least reducing harmful time lags between medical rehabilitation vocational guidance training and placement International standards adopted by the International Labour Organization in 1955 have encouraged developments along these lines in many countries

In several countries without special rehabilitation acts social insurance laws contain provisions for assistance during rehabilitation In Belgium there is a special vocational rehabilitation fund within the sickness and disability insurance program from which [illegible] ing [illegible] travel [illegible] National Pensions Board which is responsible for the old age and invalidity program and until recently also for the health insurance system issued instructions in 1946 to all local sickness funds to the effect that steps should be taken to provide rehabilitation services to all those cases where medical care or vocational rehabilitation was considered advisable To bring about this procedure co operation among the board its local committees and sickness funds was stressed

It appears that health and disability benefit programs are increasingly being linked more closely with rehabilitation services in Europe The tendency in many countries to bring various social security systems such as sickness invalidity and workmen s compensation programs together into a more unified administration may facilitate this process On the other hand the shortage of facilities for medical and vocational evaluation of those applying for cash benefits is still a deterrent in efforts to make rehabilitation services available to all claimants The inadequacy of existing rehabilitation facilities in most countries has also been a great obstacle in this respect

In some countries the social security agencies have actively promoted and financed rehabilitation facilities In France, for example the Social Security Funds have established several rehabilitation centers and also subsidized private facilities

In the social security laws of a number of countries as in the United States, there are provisions to the effect that failure of the beneficiary to avail himself of rehabilitation services, when such exists, is ground for suspension of the cash benefits In Sweden for example, the National Pensions Law of 1946 prescribes that the disability pension may be totally or partially suspended should the insured person refuse to [illegible]

[illegible] ity *In France* benefits provided by the Social Security Funds for extended sickness may be *discontinued* if the recipient refuses to take advantage of rehabilitation services made available to him by the [illegible]

[illegible] dom

Similar tendencies can be noted in the United States Some states already provide that the cost of rehabilitating injured workmen should be a cost of the workmen's compensation program Legislation covering federal civilian employees injured on the job provides for this as does legislation for veterans Proposals are pending to provide for payment of rehabilitation costs of insured disabled persons from the social security system in order to provide additional funds to expand rehabilitation services to meet pressing needs

It should be noted that the disability insurance amendments of 1956 to the Social Security Act provide that all disabled individuals applying for a determination of disability 'shall be promptly referred' to a state vocational rehabilitation agency and that any individual who "refuses without good cause to accept rehabilitation services" shall have his benefits suspended Another interesting feature of the 1956 law is that an individual who is working under a vocational rehabilitation plan is still eligible for his disability insurance benefit during the first 12 months he is working under such an arrangement The purpose of such a "sheltered' arrangement is to enable the disabled individual to obtain work experience and to permit him a period of time to adapt to his new work assignment without loss of his benefit. In addition the Federal Vocational Rehabilitation Act of 1954 provides for co-operative relationships with agencies relating to public welfare, veterans, and the employment service, among others.

Legislation passed by Congress in 1956 provided that federal funds could be used to match state expenditures for services to needy aged, disabled and blind individu [illegible]

persons who are not rehabilitable for vocational purposes.

In both Europe and the United States increased attention and emphasis is being given to rehabilitation The exchange of ideas, experience, and personnel has speeded up during the last 10 years Through the United Nations, a co-ordinated program has been established which was adopted in a resolution passed by the Economic and Social Council in August, 1950 Various international organizations participated in the preparation and administration of this program A comprehensive review of international experience, trends, and developments, entitled "Rehabilitation of the Physically Handicapped," appeared in the *International Social Service Review*, March 1957, published by the Department of Economics and Social Affairs of the United Nations Only very little seems to have been done so far to extend rehabilitation to older persons As experience develops, we may expect somewhat greater emphasis to be given to older persons This will require a de-emphasis on the vocational aspects and an expansion of the social

potentialities of rehabilitation While some of the European experience on administrative relationships may not be wholly pertinent or transferable to the American scene, it appears that closer co ordination of rehabilitation with many other types of health education, labor, and social security institutions is a most likely development in Europe and the United States

VII Minimum International Standards

The wide variety of old age benefit plans in operation and their frequent modification make it impossible to compare European programs as a whole with the United States program Differences in wage levels prices the extent of private pension plans and similar factors make simple comparisons impossible Even comparisons of separable elements, such as the retirement age or the relative adequacy of benefits, can not be made without realizing that one element taken out of context is not the entire story The apparent liberality or illiberality of a single provision cannot be judged by itself A low retirement age might be coupled with low benefits, while a high retirement age might be coupled with high benefits To appraise the adequacy of a program the whole plan would have to be taken into account in its total economic and social setting This obviously is a large and almost insuperable task

TABLE 4

Countries Ratifying Old Age Survivors or Disability Branches of the 1952 Convention on Minimum Standards of Social Security as of December 31 1957*

Country	Old Age	Survivors	Disability
Denmark	X		X
Greece	X	X	X
Israel	X	X	
Italy	X		
Norway	X		
United Kingdom	X	X	
West Germany	X	X	X
Yugoslavia	X	X	

* In a number of instances a country has not ratified with respect to a particular branch of social security but has a rather

The International Labour Office has attempted not only to establish methods of comparing the adequacy of different old age programs but to set standards for determining their status In 1952 the International Labour Conference adopted an International Convention on Minimum Standards of Social Security The convention covers nine branches of social security Three of the branches are old age survivor and disability benefits—each type of benefit being counted as one branch

At the end of 1957 nine countries had ratified at least three of the nine branches Eight countries had ratified the old age five the survivors and three the disability branch (see Table 4) Although the United States has not ratified the convention it appears that the old age and survivors insurance (but not the disability) provisions of the Social Security Act would fully meet the requirements of the convention The United States also would meet the requirements in unemployment insurance, and hence it could comply in three branches of social security and could ratify the convention if it wished There is no present indication that the United States will ratify it The United States has taken the position that ratification of conventions which are based on provisions of state operated programs is not constitutionally possible

The Minimum Standards Convention contains a number of highly technical and complex provisions, including alternatives which are used to determine whether a country meets the minimum standards outlined in the convention Provisions are included as to the extent of coverage, the scope of the contingency qualifying conditions and amount and duration of benefits Some modifications of the general standards are permitted for underdeveloped countries, special groups of workers (such

as seamen who are excluded from the con vention) federal states the treatment of aliens and similar matters

The two major provisions of the Mini mum Standards Convention relating to old age benefits are as follows

1 Age 65 and retirement although a higher age is permitted if the working ability of elderly persons is considered In actuality therefore the retirement age is almost com pletely flexible and the figure of 65 is merely a guide.
2 Benefits for a typical worker should be 40 per cent of earnings for a man and wife of pens onable age but could be 30 per cent if a shorter qualifying requirement is made The United States system would have to meet the 30 per cent requirement since it has a relatively liberal qualifying cond tion —a maximum of 10 years (40 quarters of coverage)

For the survivors benefits a 5 year qual ifying requirement and a benefit of 30 per cent of earnings for a widow and two chil dren are required The United States pro gram more than meets this requirement

For disability insurance benefits the re quirement for benefits is 40 per cent of earnings for a man wife and two children if the qualifying requirement is 15 years of contributions or 30 per cent if it is 5 years Since the United States pays disability in surance benefits only to persons age 50 or over it does not meet the standard for rat ifying this branch

The International Labour Office has also prepared suggestions for a convention on advanced standards of social security These however have not been considered by the International Labour Conference up to this time (1959)

VIII Adequacy in Relation to Program Objectives

When Sir William (later Lord) Bev eridge publ shed his famous report *Social Insurance and Allied Services* in 1942 he advocated a cautious and conservative pol icy on increasing the amount of the old age pension in Great Britain stating 'It is dangerous to be in any way lavish to old age, until adequate provision has been as sured for all other vital needs such as the prevention of disease and the adequate nutrition of the young (par 236) Bev eridge s statement raises many controver sial and complex issues What is 'ade quate" provision for the aged and other groups in the community?

There is no single simple objective standard for determining the long run ade quacy of all types of old age benefits Con cepts of adequacy can and do vary Bev eridge s concept of adequacy for social in surance benefits in Great Britain differs from ours in the United States Beveridge (1942) stated that social insurance should aim at guaranteeing the minimum income needed for subsistence determination of what is required for reasonable human subsist ence is to some extent a matter of judg ment estimates on this point change with time and generally, in a progressive com munity change upwards' p 14

It is relatively much easier to indicate in what respect particular benefits are inade quate at a given moment of time than to define adequacy as a timeless standard It is easier to describe inadequacy than to determine adequacy

Adequacy of benefit protection cannot be divorced from other objectives and characteristics of a specific program It is important to define the objectives and characteristics of each risk and to obtain general agreement on them Standards of adequacy among the social insurance pro grams in the United States differ with re spect to the risk Thus a higher proportion of wage loss is usually provided for sho t term

... a very important factor in determining the level of benefits in social insurance Hence in the social insurance programs in the United States there are d fferentials in benefits As Professor J Douglas Brown has said ' Differentials as a factor in motivation must be measured

by the response they receive, not by their arithmetic The response to a thousand dollar differential among university professors is very different from its response among big league ball players"

In our incentive economy "equity' is an important factor to be considered as well as "adequacy" in determining the level and character of social insurance benefits Is it possible to achieve a reasonable state of equity *and* adequacy, or must one factor be achieved at the expense of the other?

Benefits in various programs are a compromise among adequacy, motivation, equity, and other factors Among these other factors are costs the desirability of having minimum and maximum benefits, and administrative considerations related to prompt and efficient payment of benefits

In the legislative evolution of any program consideration must be given to the social priority of various improvements Not all elements are of equal importance in improving the benefit adequacy of a program In terms of adequacy of the program as a whole, there are a number of factors to be given consideration in addition to the level of benefits Among these factors are the eligibility for benefits, duration of benefits classes of beneficiaries types of benefits, etc Value judgments enter into decisions of priorities There is no substitute for judgment in this area

Costs are a major factor in decisions on adequacy Innumerable proposals have been made for the amendment of the Old Age and Survivors Insurance Program The problem is one of evaluating each of these in terms of needs, priorities and effects on the individual and the economy?

It is possible for benefits to be inadequate for some individuals, while they may be 'too adequate" for others The latter situation may arise when a benefit is payable under more than one program for the same risk or when allowance is made for the non taxable status of benefits It may not always be possible to solve the problem both of inadequacy and of "overadequacy" at the same time

Tying the level of social security benefits *automatically* to changes in the consumers' price index raises many difficult problems Despite the European experience, it does not appear likely to be accepted in the United States, at the present time, as a solution to the adequacy of benefit problem In the first place, such a proposal might tend to result in the impression that the basic benefits are "adequate" and only need adjustment to the price level (although it still would be possible to have the basic benefit raised from time to time) In addition, such a proposal would be opposed on the grounds that it *might act as an incentive to inflation* or at least affirmatively would not encourage price stability Finally, it provides for dealing with the benefit side of the program without simultaneously considering the cost side

It is also doubtful whether it is yet feasible in the United States to adjust automatically various other provisions of the program to changes in economic conditions From time to time consideration has been given to various methods of modifying the provisions of the social security system so that the program will have an even more important anticyclical effect than it might have under the present provisions of the law For instance suggestions have been made for reducing the contribution rates during periods of low business activity and increasing them during periods of full employment

Several practical problems arise in the consideration of the desirability and workability of any such proposals Based on past experience, Congress has not been very favorable to the insertion of automatic escalator clauses into the statutes The effect of any such provision is to delegate the law making power to some administrative agency to determine the occurrence of specific events which affect the rights of individuals and the economy While the discretion of the administrative agency might be almost none whatsoever, nevertheless the effect of any such proposal might be

considered a serious abrogation of the legislative authority

While it could be argued that there would be no real abrogation of legislative authority by Congress under any such proposal since Congress could change the law at any time it is probable that the precedent making effect of any such proposal would result in hesitation by Congress before enacting any such proposal Although various escalator clauses have been considered from time to time in terms of increases in veterans benefit and other fixed statutory payments to individuals Congress has always indicated its unwillingness to adopt any such proposals since it is pointed out *that it is in session* every year and can make the necessary adjustments in any legislation in the light of what Congress determines are *all* the relevant facts at the time

As in the German law and the Swedish and British proposals it would be possible to have a built in factor in the law adjusting the maximum social insurance benefit to changes in wages

Research and statistical efforts in the field of adequacy of benefits must proceed on a number of fronts at the same time Based on the European experience it is clear we will need more adequacy studies in the United States in the future and we *will need them* more promptly The problems of determining adequacy of social insurance benefits will become more complex as the various forms of private benefits expand The level of living enjoyed by beneficiaries will be provided from more than one source of income

A very important factor in determining the adequacy of social insurance benefits is whether medical care is financed *on a prepayment basis* (i e not out of pocket) If comprehensive medical care *is afforded* the adequacy of cash benefits is increased For instance aged persons ordinarily must allocate a substantial portion of their retirement incomes for out-of pocket medical expenses To the extent that a larger portion of medical costs are met by prepayment arrangements the more adequate will be their cash benefits

Another important factor is the extent of homeownership To the extent that beneficiaries own their own homes or are paying for their own homes or have substantial rental commitments the adequacy of their benefits may be affected Housing costs are a substantial and variable factor in the adequacy equation (For an interesting discussion of "benefit rates and the problem of rent" see Beveridge 1942, Part III, Sec I) It appears that the long run improvement in the adequacy of benefits of social insurance benefits will depend more upon relating and adjusting changes to wage and productivity increases rather than to price changes or family budget figures

As the standard of living and productivity rises for the community as a whole, the level of all social insurance benefits and public assistance payments also should tend to rise No one in the United States has yet devised a satisfactory formula to do this automatically It might be possible to accomplish such improvements in benefits through the legislative process on an *ad hoc* basis but based upon past experience it may not be possible to do so as promptly as would be desirable Is it possible to do so more promptly? In order to *do so there must be more* extensive data bearing on the adequacy of benefits.

Adequacy of social insurance benefits *in many countries* (Great Britain Canada, and some thirty other countries) is affected by family allowance payments Barring a *serious decline* in business conditions *or a* marked change in attitudes resulting in *more favorable* support for such allowances it does not seem likely that the United States will adopt such a program in the foreseeable future

An advisory council on social security might well be established to evaluate periodically the adequacy of the protection afforded under all public and private security *programs* in the United States Such an evaluation should take into account the effects of existing programs and various pro-

posals on the individual, the family, and the economy European experience could be reviewed and made available for further consideration

In concluding this very brief review of some of the problems common to the development of old age benefit programs in Europe and the United States, the following statement by Max Lerner is of interest

> Yet despite what remains to be done America has *grappled with the problem* of security sometimes with an inventiveness that has added to the European experience instead of merely imitating it And in doing so it has *passed through* a revolution in action thought and feeling which makes its welfare structure *wholly different* from the America of the 1920s which most European commentators still take as their *prevailing image* [1957 p 131]

IX Summary of Major Provisions of Eleven Countries

Two documents in Part II summarize the major provisions of the old age benefit programs of eleven western European countries in outline form These summaries were prepared by the Division of Program Research of the Social Security Administration Department of Health Education and Welfare

The eleven countries for which summaries are included are Belgium Denmark Finland France West Germany Great Britain Italy the Netherlands Norway Sweden and the U S S R A wide variety of provisions is included in these countries

The information generally represents the status of the programs in 1957 One document deals with cash benefits under the old age programs, another with medical care insurance for pensioners

Because of the almost infinite variety of provisions in European old age benefit programs, it is not possible to make even the simplest generalization without the possibility of some exception For those who wish to ascertain to what extent the European systems have a certain type of provision or not, the most useful and recent classification of provisions will be found in *Old Age Insurance*, a report made at the International Social Security Association XIIIth General Meeting London May 1958 by R J Myers and Arnold Saxer Mr Saxer s report contains information on twenty two European countries

References and Bibliography

Abel-Smith B, and Townsend P 1955 *New pensions for old* London Fabian Publications Ltd

Anonymous 1953 Private pension plans in six countries Social Security Bull August pp 10 17

——— 1959a Social security in the Union of Soviet Socialist Republics *Ibid*, August pp 3 7

——— 1959b New graduated retirement benefits in Great Britain *Ibid*, September, pp 4-9

——— 1959c New graduated pension system in Sweden *Ibid* November pp 13 17

Beveridge Sir William 1942 *Social insurance and allied services* New York Macmillan Co

British Labour Party 1957 *National superannuation Labour s policy for security in old age* London Labour Party

Clark R M 1959 *Economic security for the aged in the United States and Canada* Vols. 1 and 2 Ottawa Department of National Health and Welfare

Cohen W J and Farman C H 1955 Social security programs throughout the world January 1955 Bull Internat Social Security A September-October

de Schweinitz K 1943 *England s road to social security from the Statute of Laborers in 1349 to the Beveridge Report of 1942* Philadelphia University of Pennsylvania Press

Friis H 1959 Comparison of benefits in the Danish social security legislation Bull Internat Social Security A January-February

Gerig D S 1955 Pensionable age under old age pension schemes Internat Labour Rev 72 (October) 262-82

Great Britain Government Actuary 1958 *Occupational pension schemes* London H M Stationery Office

Great Britain Guillebaud Committee 1956 *Report of the Committee of Enquiry into the cost of the National Health Service*

(Cmd 9663) London H M Stationery Office.

GREAT BRITAIN MINISTRY OF PENSIONS AND NATIONAL INSURANCE 1958 Provision for old age the future development of the National Insurance Scheme. (Cmd 538) London H M Stationery Office

GREAT BRITAIN NATIONAL INSURANCE ADVISORY COMMITTEE 1956 Report of the National Insurance Advisory Committee on the question of earnings limits for benefits (Cmd 9752) London H.M Stationery Office

GREAT BRITAIN PHILLIPS COMMITTEE 1954 Report of the Committee on the Economic and Financial Problems of the *Provision for Old Age* (Cmd 9333) London H M Stationery Office.

HOHAUS R A 1948 Equity, adequacy and related factors in old age security *In* W HABER and W J COHEN (eds), Readings in social security New York Prentice Hall, Inc.

HOHMAN, HELEN FISHER 1940 Old age in Sweden Washington, D C Social Security Board

INTERNATIONAL LABOUR OFFICE 1936 The International Labour Organization and social *insurance* Geneva International Labour Organization.

——— 1942 Approaches to social security an international survey Geneva International Labour Organization

——— 1949 Post war trends in social security Internat Labour Rev June, July, and September

——— 1950 Social security in agriculture *Ibid* February and March

——— 1955 [illegible]

[illegible]

sociation [illegible] Social Security As

——— 1958 Old age insurance [illegible]

[illegible]

LERNER, M 1957 America as a civilization New York Simon & Schuster

MYERS, R. J 1952 Minimum standards of social security new international convention Social Security Bull, 15 (October), 3–10

——— 1958*a* International trends in social security Bull Internat. Social Security A., 11 (January–February), 41–51

——— 1958*b* Old Age, Survivors, and Disability Insurance financing basis and policy under the 1958 amendments Social Security Bull., 21 (October), 15–21, 39

NELSON, G R. (ed) 1953 Freedom and welfare Denmark Ministry of Social Affairs

ROBSON, W A 1957 The welfare state. London Oxford University Press

SELDON, A. 1957 Pensions in a *free society* London Institute of Economic Affairs

STOCKMAN, H W 1957 History and development of social security in Great Britain Bull Internat Social Security A, 10 (January–February), 3–71

SWEDEN PENSION COMMITTEE 1950 Proposal for a general pension insurance in Sweden Oslo Swedish Government

TITMUSS, R. M 1959 Essays on the welfare state New Haven, Conn Yale University Press

UNITED NATIONS 1952 Methods of administering assistance to the needy New York United Nations

U S COMMITTEE ON ECONOMIC SECURITY 1937 Social security in America Washington, D C Government Printing Office

U S [illegible]

[illegible] Advisory Council on Social Security to the Senate Committee on Finance (Sen Doc 208 [80th Cong, 2d sess]) Washington D C Government Printing Office

U S SOCIAL SECURITY ADMINISTRATION, DIVISION OF PROGRAM RESEARCH 1958 Social security programs throughout the world, 1958 Washington, D C Government Printing Office.

——— 1959 West German Parliament approves general increase in pensions ("Research and Statistics Note," No 1) Washington, D C Social Security Administration (Mimeographed)

V

Housing and Community Services

WILMA DONAHUE

Europe, like the United States, has experienced an extreme housing shortage, especially since the last world war, but, unlike the United States, it is not neglecting its older citizens in the development of housing programs to meet the shortage crisis. In keeping with their philosophy that the aged have equal rights with the young to the goods and benefits of society, the various countries, as they build housing for young families, are including a reasonable proportion of units especially designed for the aged. The United States, only now beginning to take similar account of the housing needs of the elderly, is fortunate in being able to take advantage of the longer experience of western Europe and the United Kingdom for guidance in its planning.

Before the twentieth century the policy of most European countries for housing old people was to provide communal type, institutional arrangements for the indigent sick or frail who were without families or whose relatives could or would not care for them. The administration of these workhouses or poor law institutions was harsh and often punitive, the environment unstimulating and custodial in nature. Medical care was minimal. Residents were forced to work for their keep as long as they were able to carry on. In general, there was much neglect which reflected the low esteem in which society held the individual unable to maintain himself in the community.

The reform in social policy toward the elderly, which began in the early decades of the present century, has resulted not only in the establishment of such measures as pension schemes and invalidity insurance but also in the development of new approaches to housing and living arrangements. This chapter will (1) provide a review of the housing trends and the means of meeting the housing needs of older people in several European countries, (2) identify the concepts and principles embodied in the housing programs and designs, and (3) describe the community services provided to make possible more effective utilization of existing housing and living arrangements as well as the newer types of housing developments.

I. Housing Trends and Factors in European Countries

There is a marked contrast between the countries of southern Europe and those of the more northerly countries of western Europe. In the former housing for the elderly is still restricted largely to institutions for the indigent supported by statutory and religious organizations. Many of these are structures built one or more centuries ago which have undergone a degree of modernization. Some progress has been made in Switzerland and West Germany, but the most enlightened and vigorous reforms have taken place in the Scandinavian countries, the Netherlands and the United

Kingdom An assessment of housing trends, therefore has to be confined largely to these countries Note might be made however that there is evidence that France and Italy when able to do so will follow the current policies of the other countries

A An Overview

At least two major factors influenced the trends in housing older people First was the institution of universal pension schemes which made old people financially capable of paying for their own maintenance separate from their families and outside public assistance institutions When they were able to be independent in the selection of housing it was natural that old people should call attention to their special needs by seeking accommodations which were designed to match their financial and physical status The second major factor influencing housing was a new appreciation of the fact that good social health requires that members of all age groups be housed in accordance with their particular needs Sweden has gone further than most other countries in the adoption of this principle and has declared through legislative action that old people have the same right as younger groups to share equally in all the social programs including housing As a result of the operation of these factors, a diversification of housing and living arrangements has come about not only in Sweden but also in Denmark the Netherland Great Britain and other countries Three general categories—independent [illegible]

and nursing care—can be identified

INDEPENDENT HOUSING

One housing principle adopted quite universally in Europe and the United Kingdom is that old people should continue to live in their own homes as long as they are physically and mentally able to do so Widespread acceptance of this principle has fostered diversity of accommodations to compensate for diminished physical energy and reduced financial resources with the result that, although still limited, independent quarters have been provided in most countries through a program of (1) construction of new specially designed accommodations and (2) conversion and remodeling of existing dwellings

In general, independent housing is designed to permit the individual the kind of privacy and freedom enjoyed by younger people while at the same time providing for ease of housekeeping and safety of movement within the dwelling space The most common types of accommodations provided are flats and apartments in buildings of two or more stories (more often than not without elevators), motel type apartments and detached cottages or bungalows These various types may be found grouped in one or more sections of the city or in special housing estates they may be arranged in blocks within the residential areas of the community, or they may be distributed throughout the housing developments which accommodate the younger age groups The newest old age homes, especially in the Netherlands, also often include cottages for the more able bodied elderly

COMMUNAL HOMES FOR THE NORMALLY AGED

One of the significant developments in housing since the last world war has been a more perceptive analysis of the need for homelike accommodations for those aged persons who may be so frail and disabled that they need oversight and some assistance with the activities of daily living but who do not need constant medical care and nursing service

Thus, in 1947, the Swedish Riksdag adopted a declaration of principles with [illegible]

be housed in old people's homes, while those who were sick were to be admitted to hospitals and nursing homes for chronic patients or the mentally ill (Swedish Social Welfare Board, 1952). The 1957–58 Riksdag reaffirmed these principles (Berggren, 1958a) and thus encouraged the already clearly established trend of reserving old people's homes exclusively for the normally aging and of designing such homes to suppress all features conveying the impression of an institution.

The United Kingdom, likewise, has sought to serve the housing needs of frail elderly people unable to maintain their own households by providing small home-like residential accommodations. Shenfield (1957) states that in 1947 the Ministry of Health pointed out "the need to go forward with the creation of homes which would provide for about 30 or 35 elderly residents." The National Assistance Act of 1948 included legislation which placed responsibility on the local authorities to provide accommodations for the elderly which would be substitutes for normal homes.

Just after World War II the Netherlands adopted a policy of providing apartment living within old age homes for couples in need of oversight, thus reducing somewhat the institutional character of the homes (Bouwcentrum, 1955) and maintaining a semblance of homelike living for the couples.

The Europeans point out a psychological advantage in separating the housing of the frail or disabled elderly from that of the sick or mentally deteriorated old people. Dr. Ali Berggren, chief of the Division of Social Care, Royal Social Board of Sweden, compared the incidence of illness among essentially well persons living in an old age home where sick people were also housed with that occurring among a second group living in an old age home where there were no sick persons. He reported that the incidence of illness among the able-bodied was significantly higher in the former home than in the latter.

SHELTER FOR THE CHRONICALLY ILL

The chronically ill old person in Europe is most frequently housed in a large institution which is a hospital or which has a hospital-like character. The nursing home as it is known in the United States, although present, is not yet so common in many parts of Europe. Hospitals devoted entirely to geriatric patients are fairly prevalent, but as an organized system are probably best developed in the United Kingdom. These hospitals provide acute care and rehabilitation services for the chronically ill. If there is no suitable place for recovered patients in the community, or if rehabilitation fails, the hospital may become a permanent shelter for them. The United Kingdom has also established a few "halfway houses" which are convalescent units halfway between hospital care and living at home. One type—rest homes—cater to the older person who is chronically sick but who does "not need the expensive service of hospital care [but does] need constant attention and help of a simpler kind and could not manage at home" (Shenfield, 1957, p. 165).

The other type—halfway convalescent homes—care for patients sent from geriatric hospitals before returning to independent living. In the latter type, the patients are in transit, in the rest homes they are likely to remain until a terminal illness. Halfway convalescent homes are not provided by statutory services, but these and the rest homes have been provided by voluntary bodies. They are not part of the National Health Services.

In several countries—Sweden, Denmark, Finland and Germany, for example—are to be found some very large old age communities which include accommodations ranging from those for the able-bodied through those for persons requiring long-term hospitalization. Sabbattsberg in Stockholm (Mehr, 1957), De Gamles By in Copenhagen (Hjem, 1951), Tievverko Sovitetaan in Helsinki, and Richler Heemstatten in Cologne, Germany (Roggendorf

1953), are examples for developments which include hospital and nursing units, congregate living arrangements for the frail and private quarters for those able to care for themselves.

In the Netherlands the commercial nursing home is a common institution, and, although there is no general policy with reference to where nursing care shall be given some old age homes make it a practice to send sick residents to be cared for in homes of this type Although there is currently a very strong policy for abolishing the proprietary nursing homes, the Netherlands must still use them because the number operated on a non profit basis is still too limited to meet the need A plan for including nursing home care as a part of the obligatory health insurance for persons with an income up to approximately 7000 guilders is expected to enlarge materially the possibilities for establishing non profit nursing homes There has been considerable dissatisfaction with the custodial type of care offered in many of the proprietary nursing homes and there has also been a question of the specific place of nursing homes in the total medical-care pattern for the aged The Dutch National Committee of Old People s Care therefore employed Bouwcentrum (Housing Center) of Rotterdam to carry out a study of the nursing homes and to make recommendations regarding the type of care that should be offered by these homes and to suggest detailed specifications for building and operating them On the basis of the study it was recommended that the nursing homes should continue to be operated independently but should include comprehensive rehabilitation services and also should be closely allied to local hospitals for direction of medical treatment (Bouwcentrum 1955)

COMMUNITY SERVICES

Application of the principles of continuing independent living arrangements for older people as long as possible soon made obvious the fact that many people would be able to maintain their households only if they had some household help and other services brought to them Thus, as Shenfield (1957) points out, "it is important to consider housing, domiciliary services and communal care together because a co-ordinated policy in the provision of all three is the only way to make the most effective use of them all, both from the point of view of the needs of older householders and *from that of the cost to the* community" (p 134)

Perhaps because of the earlier and more clearly established decision to help older people continue to live independently in their own homes, most of the European countries are far ahead of the United States in the development of community services for the aged The United Kingdom, the Netherlands, Denmark, Sweden, and, to a lesser extent, Switzerland West Germany, and France offer a fairly comprehensive range of services, and some of the countries provide special training courses for persons wishing to prepare to serve either as volunteers or as paid workers in these programs

The costs of the community service programs—health home helps, food services, social and recreational—are considered much more economical to society than the building and maintenance of institutional types of housing that would be necessary for the rather large marginal group who are now able, through relatively extensive use of these community services, to care for themselves

Before discussing the detailed methods and programs for meeting the housing and community service needs of the elderly, consideration will be given to some of the factors which have determined the character direction, and magnitude of the solutions undertaken

B Factors in Housing the Aged

The countries of western Europe have been forced to give attention to the special housing needs of older people for about the

be housed in old people's homes, while those who were sick were to be admitted to hospitals and nursing homes for chronic patients or the mentally ill (Swedish Social Welfare Board, 1952) The 1957–58 Riksdag reaffirmed these principles (Berggren, 1958*a*) and thus encouraged the already clearly established trend of reserving old people's homes exclusively for the normally aging and of designing such homes to suppress all features conveying the impression of an institution

The United Kingdom likewise, has sought to serve the housing needs of frail elderly people unable to maintain their own households by providing small home like residential accommodations Shenfield (1957) states that in 1947 the Ministry of Health pointed out "the need to go forward with the creation of homes which would provide for about 30 or 35 elderly residents" The National Assistance Act of 1948 included legislation which placed responsibility on the local authorities to provide accommodations for the elderly which would be substitutes for normal homes

Just after World War II the Netherlands adopted a policy of providing apartment living within old age homes for couples in need of oversight thus reducing somewhat the institutional character of the homes (Bouwcentrum 1955) and maintaining a semblance of homelike living for the couples

The Europeans point out a psychological advantage in separating the housing of the frail or disabled elderly from that of the sick or mentally deteriorated old people Dr Ali Berggren chief of the Division of Social Care Royal Social Board of Sweden compared the incidence of illness among essentially well persons living in an old age home where sick people were also housed with that occurring among a second group living in an old age home where there were no sick persons He reported that the incidence of illness among the able bodied was significantly higher in the former home than in the latter

SHELTER FOR THE CHRONICALLY ILL

The chronically ill old person in Europe is most frequently housed in a large institution which is a hospital or which has a hospital like character The nursing home as it is known in the United States, although present, is not yet so common in many parts of Europe Hospitals devoted entirely to geriatric patients are fairly prevalent but as an organized system are probably best developed in the United Kingdom These hospitals provide acute care and rehabilitation services for the chronically ill If there is no suitable place for recovered patients in the community, or if rehabilitation fails, the hospital may become a permanent shelter for them The United Kingdom has also established a few "halfway houses" which are convalescent units halfway between hospital care and living at home One type—rest homes—cater to the older person who is chronically sick but who does "not need the expensive service of hospital care [but does] need constant attention and help of a simpler kind and could not manage at home' (Shenfield, 1957 p 165)

The other type—halfway convalescent homes—care for patients sent from geriatric hospitals before returning to independent living In the latter type, the patients are in transit, in the rest homes they are likely to remain until a terminal illness Halfway convalescent homes are not provided by statutory services but these and the rest homes have been provided by voluntary bodies They are not part of the National Health Services

In several countries—Sweden Denmark Finland and Germany, for example—are to be found some very large old age communities which include accommodations ranging from those for the able bodied through those for persons requiring long term hospitalization Sabbattsberg in Stockholm (Mehr, 1957), De Gamles By in Copenhagen (Hjem, 1951), Tieverko Sovitetain in Helsinki, and Richler Heemstatten in Cologne, Germany (Roggendorf

1953) are examples for developments which include hospital and nursing units congregate living arrangements for the frail and private quarters for those able to care for themselves

In the Netherlands the commercial nursing home is a common institution and although there is no general policy with reference to where nursing care shall be given some old age homes make it a practice to send sick residents to be cared for in homes of this type Although there is currently a very strong policy for abolishing the proprietary nursing homes the Netherlands must still use them because the number operated on a non profit basis is still too limited to meet the need A plan for including nursing home care as a part of the obligatory health insurance for persons with an income up to approximately 7000 guilders is expected to enlarge materially the possibilities for establishing non profit nursing homes There has been considerable dissatisfaction with the custodial type of care offered in many of the proprietary nursing homes and there has also been a question of the specific place of nursing homes in the total medical-care pattern for the aged The Dutch National Committee of Old People's Care therefore employed Bouwcentrum (Housing Center) of Rotterdam to carry out a study of the nursing homes and to make recommendations regard ng the t ... [illegible]

... them On the basis of the study it was recommended that the nursing homes should continue to be operated independently but should include comprehensive rehabilitation services and also should be closely allied to local hospitals for direction of medical treatment (Bouwcentrum 1955)

COMMUNITY SERVICES

Application of the principles of continuing independent living arrangements for older people as long as possible soon made obvious the fact that many people would be able to maintain their households only if they had some household help and other services brought to them Thus, as Shenfield (1957) points out "it is important to consider housing domiciliary services and communal care together because a coordinated policy in the provision of all three is the only way to make the most effective use of them all, both from the point of view of the needs of older householders and from that of the cost to the community" (p 134)

Perhaps because of the earlier and more clearly established decision to help older people continue to live independently in their own homes most of the European countries are far ahead of the United States in the development of community services for the aged The United Kingdom, the Netherlands Denmark Sweden and to a lesser extent Switzerland West Germany, and France offer a fairly comprehensive range of services and some of the countries provide special training courses for persons wishing to prepare to serve either as volunteers or as paid workers in these programs

The costs of the community service programs—health home helps food services, social and recreational—are considered much more economical to society than the building and maintenance of institutional types of housing that would be necessary for the rather large marginal group who are now able through relatively extensive use of these community services to care for themselves

Before discussing the detailed methods and programs for meeting the housing and community service needs of the elderly consideration will be given to some of the factors which have determined the character direction and magnitude of the solutions undertaken.

B Factors in Housing the Aged

The countries of western Europe have been forced to give attention to the special housing needs of older people for about the

same reasons as those now confronting the United States The underdeveloped countries will be faced with the same factors as they move on to an urbanized and technological order

INCREASE IN NUMBER AND PROPORTIONATE SIZE

The first factor influencing the development of special housing for older people is the change in the population structure In all countries of Western culture there has been an increase in both the absolute number of old people and the proportionate size of this age group All projections of population trends indicate that for the next several decades the increase will continue, if, as Hauser and Vargas point out in chapter ii, the mortality and fertility rates continue to decline

In comparison to the United States most of the countries of western Europe and Great Britain already have a considerably larger proportion of old people in their populations Currently in the United States 8 7 per cent of the population is 65 years of age and over Only Italy among western European countries has a lower proportion, about 8 1 per cent, while France ranks highest with approximately 12 per cent in the upper age group The Scandinavian countries and the Netherlands, England and Switzerland fall between these extremes To illustrate the projected increase in the proximate size of the older age group in the next few years, it can be noted that Sweden expects the 10 3 per cent in 1950 to increase to 14 per cent in 1970, the Netherlands predicts the 8 7 per cent of 1957 to change to 10 7 per cent by 1975 and to 11 1 per cent in 1980

Inasmuch as the housing needs of today's older people are still inadequately met, these projected increases in their numbers for the next few years are inevitably hastening the construction of all types of accommodations for this group

FAMILY RELATIONSHIPS

A second factor serving to increase the demand for special housing for old people is the breakdown of the extended kinship family occurring as a consequence of industrialization As Burgess points out (chap i), the nuclear family unit, consisting of one adult generation and its immature progeny, has become the common pattern in practically all Western cultures although there are variations among countries in the extent of dissolution of the family structure These differences are reflected in the housing policies

In Italy where societal and legal obligations to support elder relatives are still binding the influence of the extended family remains strong, and housing which affords independent living for the older generation is almost non-existent Usually only institutions to domicile the indigent chronically ill are provided On the other hand in Sweden England and the Netherlands where there has been some relaxation in the statutory and/or moral demands on children for the care of parents it has become a national policy to provide independent accommodations and institutions with a homelike character as substitutes Townsend (1957) in his study of Bethnal Green a London borough, and Sheldon (1948) in his survey of Wolverhampton England found that family cohesion still tends to be strong among the working classes In their study populations most older people preferred to live independently of their children but still tended to dwell in the same districts and to maintain almost daily contacts with them or other nearby relatives The government support to local housing trusts which provides small congregate accommodations for those living within the district is based on a policy which recognizes and makes possible this type of continuing family relationship In Sweden governmental subsidization for the improvement of well built old houses and inclusion of small pensioners' units within ordinary housing

developments likewise promote the maintenance of intergenerational relationships and prevents what Mehr (1954) terms "social invalidity" of the aged

Usually it is only in the more rural areas where there is still some semblance of the family as a collective unit, that any significant proportion of older people wish to live in the homes of their children In West Germany for example Friedeburg (1955) studied the preferred living arrangements of working and middleclass men when they retired and reported that while 36 per cent of those from communities of 2000 or less chose to live with their children only 7 per cent of those from cities of 100 000 or over held such a preference

ECONOMIC STATUS

Impetus was given to the establishment of national and local housing schemes in many countries because the incomes and pensions of old people were so meager that they were able to rent only the cheapest and therefore the poorest accommodations for themselves An investigation in Stockholm in 1940 showed that although there were very few slum areas in the city almost all the oldest most unsanitary, and practically doomed apartments were inhabited by elderly people The Rowntree Committee (1947) study of housing of old people in seven areas in England likewise indicated that the aged generally lived in substandard dwellings The committee however pointed out that the older person was probably housed no worse than the average individual of his class But as Shenfield (1957) cogently remarked second and third floor [illegible]

[illegible] older people press more hardly upon them than upon younger persons who are physically more able to cope with these inconveniences (p 137)

National pension rates were improved in most countries after these investigations were made, but, since the pensions are still intended only to provide a basic minimum income, the problem of being able to compete for suitable housing remains a pressing one for most old people In the Netherlands, for example, the national pension for a couple is 1584 guilders per year, food costs alone amount to 1100 guilders. In the United Kingdom at least one fourth of the aged require an assistance grant in addition to their national pensions and other retirement incomes and as many as 40 000 of Stockholm's 63 000 pensioners require rent supplements

With the building of special low rent housing and the modernization of old dwellings, significant numbers of old people now find it possible to acquire accommodations that suit their physical needs and their ability to pay Thus the social health of these countries has been materially improved especially so since the housing for old people has not been at the expense of the younger group but in proportion to it.

HOUSING SHORTAGES

As a matter of fact, the general housing shortage which existed after the last world war was a major factor in promoting housing for the aged Large quantities of dwellings had been destroyed and this situation coupled with a continuing increase in the general population, made necessary the full utilization of all available housing as well as the construction of new dwellings When studies of overcrowding showed that many old people were living in homes too large for their needs steps were taken to persuade them to seek more suitable living arrangements thus freeing the larger homes for occupancy by families with children For example the Netherlands established a policy of offering a subsidy to old people to help defray costs of moving to smaller accommodations the same step was taken by some local authorities in England While these and other measures helped to make better use of existing housing there was

still an insufficient supply for families of all ages The governments of the various countries, therefore, established subsidy programs to stimulate the construction of more dwelling units and to make special provision for the housing of the elderly

Thus simultaneous construction of homes for all age groups resulted in many instances in the inclusion of dwellings for the elderly as a part of regular housing projects thereby avoiding the segregation of the old In the Netherlands for example, the small one story motel type pensioners apartments built among the three and four story workers flats are often seen In England new bungalows or flats for older people are generally a part of an ordinary housing estate Special flatlets in converted houses are provided in a number of areas Sweden likewise, encourages the inclusion of old people s accommodations in regular apartment houses

ATTITUDES OF OLD PEOPLE TOWARD SPECIAL HOUSING

The habits and preferences of old people themselves are necessarily factors in schemes to provide special housing for their use, and the question naturally arises as to what proportion of the elderly in any community may be expected to make use of the independent housing and communal homes so carefully designed to meet their needs Neither shortages of regular community housing nor incomes too low to pay for what is available necessarily lead old people to want or to accept the special accommodations which so many communities are now providing for them Likewise neither loneliness nor lack of nearby relatives is by any means always sufficient to create a willingness to leave the neighborhood in which roots have been established over long periods of time Thus however poor their present housing situation many find it more congenial than the prospect of changing to an unfamiliar housing development or to a communal house in a neighborhood where they would be strangers

Shenfield (1957) analyzed the preference of most older people to *keep* their old homes in contrast to a few who *seek* new housing Three measures—pensions and rent allowances rent controls and security of tenure—assist old people to keep their homes although they *also tend to freeze* the use of housing Older tenants do not try to move into smaller quarters even when they can find something cheaper than the controlled rent units because they do not save any income if they are getting a rent allowance and they may lose this security of tenure by moving The pattern of most old couples living in their own homes after retirement and not with their children is firmly established It is only when considerable care is needed for elderly parents or a surviving spouse that the older person is likely to be found living in the home of one of the children

Van Zonneveld (1956) studied the attitudes of Hollanders toward old age homes in his survey of 3000 aged residents of Groningen Approximately two thirds do not favor living in communal homes Women are somewhat more favorably inclined toward this type of living than men (especially older women) and childless persons have a more positive attitude than those with children Social class is also found to be related those of lower classes especially men accept the idea of a communal home more willingly than those of the same age group from the higher classes Income is similarly related with those in the lower income bracket being attracted to communal living Health and mental status do not seem to be of importance in determining the degree of favorable attitude toward a home except that among the oldest women subject to fits of oppression there is a significant number in favor of communal arrangements

Pagani (1956) makes the observation that in Italy where pension levels and other incomes are unusually low seeking admission to a public institution is a generalized solution for aged industrial workers inasmuch as it is not unusual and in

volves no feelings of individual inadequacy or loss of dignity At the same time we can state that it is not due to a lack of family solidarity but to economic insecurity' He puts his assumption affirmatively by pointing out that the retiring worker finds himself in a crisis period characterized by (1) a low level of living (2) individual and social isolation (3) family dependence and small personal prestige and (4) emotional strain caused by his awareness of his dependency By entering an institution which removes his dependency on the family and secures for him a new sense of usefulness through participation in work programs he achieves a rational solution to the crisis This hypothesis it might be pointed out neglects the women whose occupations have been those of homemakers

The three factors which tend to predispose the elderly to enter an old age home are according to Shenfield (1957) lack of other suitable housing (suitable for independent living) inability to manage a household any longer and loneliness These reasons are similar to those on which the current pol cies of Sweden and Denmark are based that is when an individual is in need of assistance with daily activities or is in other social distress he should find a home for the aged available In practice the first two factors may hardly operate according to Shenfield except in the case of private homes taking fee paying patients by private arrangement The shortage of places in homes provided by statutory and voluntary bod es is such that only those who are clearly unable to manage independent living arrangements are likely to be considered for admittance

It is more than likely of course that attitudes toward acceptance of special accommodations particularly those of the communal type are conditioned by the widely held cultural precept that older people like others should live independently in their own homes as long as possible Too in some places rather strong vestiges remain of the societal expectation that adult children provide homes for their aged parents It may be expected that attitude toward living in the new, special accommodations will change as their advantages become more widely recognized and as old culture patterns give way to new definitions

In summary of this brief review of trends and factors influencing the housing of old people in Europe it is apparent that as in the United States there has been a great increase in the number and proportion of old people in the population that government and voluntary groups have attempted to meet the housing needs of both the able bodied normally aged and the chronically ill by providing a variety of housing types and accommodations serving different tastes and offering various services, and that such assistance has been necessary because of the shift of direct responsibility from the family to the state for the care of older family members and because the income and pension status of the aged has been insufficient for them to care for all their own needs without provision of special subsidies or services

II Meeting the Housing Needs of Old People in Europe

A more detailed comparison of ways in which the housing needs of old people are being met in Western cultures will reveal some variation in the solutions employed by different countries In general however, the similarities are much more striking than the differences in part because the economic means of the aged in all countries are limited and the national resources that are available must necessarily be shared proportionately by all age groups.

The circumstances of the elderly determine to a large extent the kinds of housing and the amounts of the various types required to provide each individual with the sort most appropriate to his situation Further considerations include the magnitude of the need (especially with respect to the extent it is being met), the role of government and private organizations in bringing

still an insufficient supply for families of all ages. The governments of the various countries therefore, established subsidy programs to stimulate the construction of more dwelling units and to make special provision for the housing of the elderly.

Thus simultaneous construction of homes for all age groups resulted in many instances in the inclusion of dwellings for the elderly as a part of regular housing projects thereby avoiding the segregation of the old. In the Netherlands, for example the small one-story motel type pensioners apartments built among the three- and four-story workers flats are often seen. In England new bungalows or flats for older people are generally a part of an ordinary housing estate. Special flatlets in converted houses are provided in a number of areas. Sweden, likewise encourages the inclusion of old people's accommodations in regular apartment houses.

ATTITUDES OF OLD PEOPLE TOWARD SPECIAL HOUSING

The habits and preferences of old people themselves are necessarily factors in schemes to provide special housing for their use and the question naturally arises as to what proportion of the elderly in any community may be expected to make use of the independent housing and communal homes so carefully designed to meet their needs. Neither shortages of regular community housing nor incomes too low to pay for what is available necessarily lead old people to want or to accept the special accommodations which so many communities are now providing for them. Likewise neither loneliness nor lack of nearby relatives is by any means always sufficient to create a willingness to leave the neighborhood in which roots have been established over long periods of time. Thus, however poor their present housing situation many find it more congenial than the prospect of changing to an unfamiliar housing development or to a communal house in a neighborhood where they would be strangers.

Shenfeld (1957) analyzed the preference of most older people to *keep* their old homes in contrast to a few who *seek* new housing. Three measures—pension and rent allowances, rent control, and security of tenure—assist old people to keep their homes, although they also tend to freeze the use of housing. Older tenants do not try to move into smaller quarters even when they can find something cheaper than the controlled rent units because they cannot save any income if they are getting a rent allowance and they may lose the security of tenure by moving. The pattern of most old couples living in their own homes after retirement and not with their children is firmly established. It is only when considerable care is needed for elderly parents or a surviving spouse that the older person is likely to be found living in the home of one of the children.

Van Zonneveld (1956) studied the attitudes of Hollanders toward old age homes in his survey of 5000 aged residents of Groningen. Approximately two-thirds do *not favor living in communal homes.* Women are somewhat more favorably inclined toward this type of living than men (especially older women) and childless persons have a more positive attitude than those with children. Social class is also found to be related: those of lower classes, especially men accept the idea of a communal home more willingly than those of the same age group from the higher classes. Income is similarly related with those in the lower income bracket being attracted to communal living. Health and mental status do not seem to be of importance in determining the degree of favorable attitude toward a home except that among the oldest women subject to "fits of oppression" there is a significant number in favor of communal arrangements.

Parani (1956) makes the observation that in Italy where pension levels and other incomes are unusually low seeking admission to a public institution is a generalized solution for aged industrial workers inasmuch as it is not unusual and in

latter group alone accounted for 30 per cent. On the other hand a study of the general hospitals in Stockholm showed that 12 per cent of the beds were occupied by chronically ill old people who would be better cared for in some other type of facility

The situation in England appears to be little different from that on the Continent Sheldon (1948) found that 11 per cent of the Wolverhampton sample were so ill or so disturbed that they were confined to bed or

oriented they needed care in a mental hospital

B Estimated Need for Housing and Community Services

If quarters in old age homes catering to the frail and disabled are needed by an estimated 10–15 per cent and if mental hospital facilities are required for another 1–3 per cent it probably may be assumed that 85–90 per cent of the elderly need and can effectively use independent living arrangements especially if special personal services are provided by the community

The need for community services for the aged is dependent upon the number of elderly people who remain in their own homes since most service is directed to this group How many of the 85 per cent living outside the institutional setting are in actual need of service is difficult to determine Factors to be considered however are age and marital status It is assumed that the older the individual and particularly if he lives alone the more and the greater variety of services needed. Yet this assumed increase in need is offset by the fact that as many as one third of those 80 years old and over live with their children and among those who do there are many who have great vitality It is probable that no general estimate of the extent of communal services needed can be made Rather it must be a matter of local determination in relation to the age and health characteristics of the total population of the community and the availability of a full range of living accommodations

C Amount of Housing Provided for Older People

Although the vigorous building programs adopted by most of the European countries following the last world war resulted in the construction of a relatively large number of dwellings the supply is still far below the estimated need Proportionately, the shortage of independent accommodations is greater than it is for communal institutions

INDEPENDENT HOUSING (FLATS ETC)

The emphasis was placed on providing pensioners flats cottages etc, because of the high cost of building and operating institutions and because it was in accordance with established aims Also since the private accommodation is usually considered an economical way within limits, to care for the elderly by utilizing the ability of old people to maintain their own households and to look after themselves social planners and housing experts are undertaking to include in many building programs a significant amount of housing of proper size and design which will make possible continued occupancy by the aged even after the appearance of considerable frailty and disablement

Sweden for the past two decades has encouraged the construction of inexpensive accommodations for the aged By 1954 between 30 000 and 40 000 pensioners dwellings had been built or somewhat over 7 per cent of all private units constructed since 1939 This proportion can be compared to the slightly more than 10 per cent of the population making up the pensioner group If only the larger cities are considered an even greater proportion of old people are housed in community built independent accommodations In Stock

about the solution of the housing problem, the costs to society, and the charge to old people themselves No country has as yet achieved an ideal plan, but noteworthy and, in some instances, striking progress is being made

A Some Characteristics of Older People Related to Housing

Although the economic status of the aged is a prime determinant of the amount and quality of housing old people can purchase for themselves, other factors less susceptible to statutory regulation may be equally important in attempts to satisfy the psychological as well as the physical needs of older people Chief among these are family relationships and general levels of physical and mental health

FAMILY STATUS

European sociologists do not predict that there will be a reversal in the tendency toward the breakdown of family structure, because they see the present trend as the inevitable outcome of the social structural transformations resulting from modern developments Therefore, if the trend continues the time will come when the family no longer serves the functions of offering shelter, care and direct, affectional relationships to the older generation, then far reaching social policies must be developed to supply substitutes, not the least important of which are housing and community services

Several comprehensive surveys, made by local communities in the United Kingdom and other countries, underscore the trend toward separate living of the generations and indicate the need for independent dwellings for the elderly The Wolverhampton study (Sheldon, 1948) showed that only 12 per cent of older people live with children and of these, the largest proportion is among the very old and the widowed Shenfield (1957) also found that approximately 12 per cent of the elderly live with their children, with the proportion increasing to one third for those over 80 years of age In the Netherlands, 11 per cent of the aged live in the homes of their children or other relatives, in France on the other hand, 25 per cent of the single elderly and 30 per cent who still have spouses live with their children Burgess gives a comprehensive breakdown of family relationships and responsibilities in chapter viii

MENTAL AND PHYSICAL HEALTH STATUS

In the absence of a system of family care and protection, the health status of older people becomes a matter of major consideration in the planning of the type number, and special features of their living accommodations The findings presented in chapters vi and vii are pertinent to the problems being considered here

The Netherlands recognizes four categories of old people with reference to health needs and housing (1) the physically able who can live independently without special help, (2) the physically restricted able to live independently with the assistance of special amenities (3) the weak, frail and somewhat disabled who need to reside in the residential home, and (4) the chronically or long term ill or disabled who require nursing home care The policy is to care for the members of the latter two categories in different homes Current national estimates based on a number of surveys (van Zonneveld, 1956), indicate that theoretically 10–14 per cent of the aged population are in need of accommodations which offer general care while 3–4 per cent are in need of nursing home care This latter figure includes 1–1 5 per cent who are mentally ill

In Sweden as already pointed out, the policy since 1947 has been to utilize the old age homes for housing the frail well aged yet an investigation made in 1950 showed that, of the 27 900 persons residing in these homes, 59 per cent were mentally disturbed senile, or chronically ill The

The Netherlands, although emphasizing the importance of older people living in their own homes, has provided a proportionately smaller number of such accommodations than some other countries Between 1945 and 1959 the Dutch built 10,955 dwellings especially designed for old people, constructed 177 old age homes and modernized 83 existing buildings to provide a total of 18,155 beds "en pension" homes Table 1 shows the distribution of the dwellings and old age homes throughout the country Table 2 shows the age distribution of residents in 1950

COMMUNAL ACCOMMODATIONS

In considering communal arrangements, it seems desirable to separate those serving only the normally aged and those which serve the chronically ill in need of hospital care It is not possible, however, to do this satisfactorily because even in those countries, such as Sweden, where the separation of these two groups is an established policy, there remain, for matters of expediency some sick old people among the normally aged

In general however, Sweden does distinguish between the old age homes which are intended for persons who *need some* form of assistance but not continuous nursing care and the nursing homes which are intended for sick persons In Stockholm in 1954 there were 1000 placed in old age homes or enough to accommodate 1 5 per cent of the pensioners in the city and 1900 placed in nursing institutions, which accounted for another 3 per cent of the older group By 1960 the city expects to increase the capacity of old age homes by one half and nursing homes by about one third In relation to the calculated number of old persons 65 years of age and over at the end of 1960, there will be 4 4 placed per 1000 aged (Dahlstrom, 1956)

The Ministry of Welfare of the Netherlands reported in 1957 that approximately 40,000 of 9,000,000 (4 3 per cent) old people lived in old age homes In Amsterdam 3 5 per cent of the aged are being accommodated in recently built institutions offering complete nursing care

Shenfield (1957) has expressed the opinion that in England the demand for care in a residential setting which provides nursing service exceeds the supply by a significant amount The National Old People's Welfare Council (1954*a*) has estimated that in London no more than 8 5 per cent of those who wish to enter communal homes are able to find space In 1956 only 71,713 of the 6 5 million persons in England of pensionable age were accommodated in old age homes (excluding 12,000 additional places in almshouses) (Great Britain, National Old People's Welfare Council, 1956)

TABLE 2*

RELATION OF AGE TO RESIDENCY IN OLD AGE HOMES, THE NETHERLANDS, 1950

Age	Total Population 65 and Over	No in Homes	Per Cent in Homes
65–69	308,714	4372	1 4
70–74	234,236	6825	2 9
75–79	147,499	8009	5 4
80–84	72,328	6504	9 0
85–90	31,714	3753	11 8

* Source Central Bureau of Statistics

It appears, then, that, when an over all estimate is made of the amount of various types of housing available, the aged, at least in several *countries* of Europe and the United Kingdom, have approximated their proportionate share of the total housing built over *the last 20* years (a statement which could not be made with reference to the United States) Accommodations for the able bodied, although larger in total amount, are proportionately much less numerous than are those for the sick and the disabled In both categories, however, the supply is still far short of the demand

holm, for example, there were (in 1956) 9000 pensioners' flats or enough to house 14 5 per cent of Stockholm's 63,000 people aged 67 and over When this comparison is based on families in place of single individuals, it shows an even larger proportion of the old age group living in independent dwellings

The housing program for old people in Denmark is similar to that of Sweden except that the national government plays a somewhat smaller role In Copenhagen, in 1951, there were about 5200 pensioners' flats, one fourth of which were occupied by couples Thus approximately 13 per cent of the 48 000 old age pensioners were housed in these flats (Danish Society, 1951, p 50) and about 3 per cent more were housed in the old people s home of Copenhagen (De Gamles By) Today, in the whole country of Denmark, there are about 250 000 pensioners, and 11 5 per cent of them live in pensioners' quarters or in municipal homes for the aged

For England it has been reported (Shenfield, 1957) that, following World War II the proportion of one bedroom houses (considered to be of a suitable size but not specially designed for old people) built by local authorities to all other housing built by these authorities was 8 per cent More recent figures supplied by Shenfield show that, by the first quarter of 1958 the proportion had increased to 18 8 per cent But owing to the lack of provision in former years and to growing needs about 20 per cent of all housing should be built suitable for the elderly to bring up to 5 per cent the proportion available to them The shortage is even worse, if anything in the provision for communal accommodations Some local authorities have over 300 persons on their waiting lists Out of 145 local authorities in England and Wales in 1958 there were 90 that had provided less than one bed per 1000 of the population (two beds per 1000 has been suggested to be the minimum provision required)

TABLE 1*

NUMBER OF DWELLINGS AND EN PENSION HOMES BUILT IN THE NETHERLANDS WITH FINANCIAL AID OF THE GOVERNMENT DURING THE PERIOD MAY 1 1945—JANUARY 1 1959

Province or City	No of Dwellings	En Pension Homes				Total No of Beds
		Extension Modernization		New Buildings		
		Homes	Beds	Homes	Beds	
Groningen	1 030	9	328	16	748	1 076
Friesland	889	10	243	24	1 246	1 489
Drenthe	506	4	68	9	616	684
Overijssel	433	5	243	4	626	869
Gelderland	936	6	494	22	1 900	2 394
Utrecht	770	13	585	11	1 527	2 112
North Holland	1 736	13	358	34	2 295	2 653
South Holland	1 935	2	57	17	1 506	1 563
Zeeland	161	5	169	7	578	747
North Brabant	865	9	381	17	1 749	2 130
Limburg	546	5	344	8	751	1 095
Amsterdam	855	1	15	2	469	484
The Hague	97			3	741	741
Rotterdam	196	1	13	3	105	118
Total	10 955	83	3298	177	14 857	18 155

* Source F H J Nestrasz (private communication 1959)

which has been generously supported by the Nuffield Foundation and the National Old People's Welfare Council which has given leadership to the development of housing for the elderly since its inception The Women's Voluntary Service for Civil Defense is another example of a voluntary group which has helped provide accommodations for old people needing care in residential clubs nursing homes and halfway houses In Switzerland also, Pro Senectute (Old People's Foundation) has stimulated and assisted local cantons and communities in their efforts to construct old people's accommodations

The gradual extension of governmental and other forms of community responsibility for older people as society has become industrialized and hence more complex is clearly manifested in the field of housing The rôle of government has become that of building and operating homes for the aged and institutions for care and treatment of the chronically ill of providing partial and full subsidies permitting low income older people to occupy good housing of setting standards for housing accommodations and of contributing leadership in giving recognition to the significance of living accommodations to the well being of older people

The church and other voluntary agencies continue to make important contributions by adding to the supply of housing and by providing administrative services for many homes for the aged—for some of those which are publicly supported as well as for those which are church supported Government and voluntary agencies are frequently joined also in extending a variety of services to elderly people in their own homes In general the European pattern finds government agencies shouldering the principal responsibility for standard setting construction and financing in the area of low income housing but often working in close partnership with non governmental organizations and associations

E Financing

State subsidization of housing programs has come to be the chief instrument through which the housing circumstances of the aged are being improved in the Scandinavian countries, the Netherlands, the United Kingdom and West Germany As a rule, financing is shared jointly but not necessarily in equal proportions between the state and the local municipality or authority Generally, financial aid takes two forms (1) rent subsidies to individuals which are made as supplements to pensions or as part of public assistance grants by way of reduced rents and (2) building grants made to non profit builders voluntary bodies or local authorities for the construction of independent units or of old age homes and for the modernization and/or conversion of large old houses into smaller living units Of course, state aid is also being made available in most countries to build long stay hospitals to accommodate the chronically ill who need continuous nursing service An indirect form of aid to housing is found in the subsidization of various organizations and agencies by federal and local governments to underwrite in part, the costs of community services which make it possible for older people to maintain their own households

Sweden affords a good example of the rôle of government in financing housing and community services for the elderly Since 1939 the state has provided special grants to municipalities and communes to build independent housing for pensioners These grants are used for (1) constructing blocks of pensioners' flats in normal residential areas, (2) including pensioners quarters in apartment buildings designed for younger families, and (3) converting old well built homes for occupancy by several elderly couples or single persons The size of the state subsidies ranges from 25 to 80 per cent of building costs depending upon local need By July 1, 1954 the state had granted construction subsidies up to

D Sponsorship

Traditionally, responsibility for the housing and care of older people was assumed by religious bodies in all countries of western Europe Gradually, as the volume of need exceeded the capacity of the churches to meet it, public agencies were required to provide various forms of care and facilities Today, government exercises principal responsibility in most countries, although its activities are usually exercised through or co ordinated with those of local authorities, religious groups, labor organizations, voluntary associations, housing trusts, and private builders

Rudd (1956) provides a brief but vivid review of the historical background to modern housing and care of the elderly In essence, he points out that during the Dark Ages the monks maintained infirmaries in their monasteries where they cared for sick and abandoned old people During the Reformation many non monastic infirmaries were established by religious groups The almshouses which grew out of these infirmaries represent perhaps the first involvement of government in the provision of housing for old people Although these institutions were publicly supported, the religious influence remained strong, and many of the almshouses included a church or chapel where the old spent their time offering prayers for their benefactors Later under the influence of the poor laws, the public almshouses lost their religious character and took on the role of workhouse, in which poverty, considered to be the result of laziness and sin, was punished by hard work Following the Middle Ages the administrators of public institutions began to develop more humane attitudes toward the residents Today there is in every country of western Europe and England in both public and private institutions a genuine effort to modernize the old structures and to introduce the newer concepts of good care Thus, in Rome, one may visit an old age home by entering a little court surrounded by what appears to be an ancient structure (the law prohibits the change of external appearances for historical reasons), but the interior has been modernized to include cheerful wards, an up-to date surgery ward, laboratories, modern kitchens, occupational therapy rooms sheltered workshops, etc Similar experiences are to be had in the Netherlands West Germany, England, and Sweden

Although governments have played an increasingly important role in providing housing for the elderly, the contributions of the church and of other agencies have remained strong During the seventeenth century, the Dutch Reformed church and Dutch merchant corporations established many old age homes in Holland In West Germany today, for example, there are 927 Evangelical church old people s homes with 147 000 beds, or enough to accommodate about 3 per cent of the population aged 65 and over

In Stockholm, near the beginning of the eighteenth century, when measures were taken to prevent distress and to eliminate begging on the part of the old each parish was charged with taking care of its own poor At that time communal homes were established by every parish (Erlandsson 1954) and in 1918 the parishes also began to build flats for old people By 1954 they had constructed 31 blocks consisting of almost 2900 flats 600 of which were for couples In 1958 the Stockholm Municipal Diet voted to build another 1000 flats to be scattered through public housing developments in 69 places

As interest in providing housing and old age homes developed, the churches and governments were joined in some countries by various organizations such as labor unions foundations voluntary associations and limited dividend housing trusts Among examples in England of voluntary bodies that have had a major influence on the de

a minimum subsistence payment, and, in sofar as the pensioner's income falls below the scale it is brought up to the statutory level The second part is the rent allow ance and is considered of the utmost impor tance Rent controls operating since the war years have recently been abolished and as a result some rents have risen

Since 1957 about 500 000 National As sistance grants have been increased to take care of the advances in rents the average increase being a little over 5 shillings (72 cents) per week In this way many old people have been able to retain their homes and meet increased rent charges

Government programs for housing the elderly are negligible or non existent in France Italy, and Switzerland but West Germany is beginning to give some atten tion to this need In such cities as Berlin and Hamburg high rise pensioner flats, usually without elevators are being built with support from the federal government The money is loaned to private builders at a very low rate of interest with a 40- or 50-year amortization period. Thus they can be offered at a low rental rate The first units built especially for old people after the war allowed only 32 square feet per apartment the size has been increased to 130 square feet now and it is hoped that, in the near future funds and material will make it possible to increase the size to 172 square feet Chronic hospitals also are be ing built with the assistance of government funds to house the sick aged In Hamburg for example a new three-story building has been added to a general hospital which serves as a central receiving point where all those admitted are screened to deter mine whether they should be cared for in the hospital or sent to an old age home

Other financial resources for housing the elderly have greatly augmented the hous ing supply and services for the aged in most countries since government interest and c [illegible]

[illegible] u ucn state and municipal subsidization has been available, it has never been enough in any country to pro vide adequately for the increasing de mands The non governmental groups have attempted to help fill the gap and have ren dered valuable aid in this respect Since in a number of European countries there has been a willingness of governmental agen cies to give some financial support to the efforts of voluntary groups the value of government expenditures has been consid erably enhanced

In the Neth [illegible]

to G de Haan, staff member of Gemeen telijke Dienst van Sociale Zaken (personal interview, 1957) The Dutch federation for the care of old people, which is composed of all top-level voluntary organizations concerned with the care of the aged, re ceives some financial aid from the govern ment for its programs of research and for inspection of old age homes There are many church subsidized old age homes in the Netherlands, and a considerable num ber of the newest and most modern ones have been built recently by both Catholic and Protestant church groups The churches are also an important source of funds for making up the difference between living costs of the aged and their old age pensions and incomes The churches and voluntary groups such as the Women's Voluntary Service, subsidize the commu nity service programs although some finan cial assistance often is provided by the government especially the local munici palities. The Red Cross provides some as sistance for occupational therapy pro grams

The Netherlands is fairly typical of vol untary effort in other countries In Eng land for example voluntary groups, upon application may receive financial assist ance from governmental sources for build ing new dwellings or converting old ones Normally housing through voluntary ef fort is provided in one of these ways the formation by local groups of special hous

the value of 102 million kronor ($20 million) in partial support of the building of 23,100 pensioners' flats (Mehr, 1957)

The construction of communal homes as well as of the independent type of living accommodations is also subsidized in large part by the state Each commune is required by law to provide a home for its aged residents The larger communities may have several large homes (five are found in Stockholm), or, in the more rural areas, several communes may form a communal union and build a single home The 2281 rural communes have thus combined to form 821 communal unions Thus the old people of rural Sweden tend to be just as well housed as those living in urban centers—perhaps even better, since the homes in rural areas are generally much smaller and more homelike

The rural communes also tend to make considerable use of the home improvement type of subsidy and loan, since it is a means for improving the standard of living of old people while at the same time making it possible for them to continue to live in their old homes and/or communities These home improvement subsidies, made separately or in combination with loans, are payable by the state up to 8000 kronor ($1544) The local municipality assumes the remainder of the cost

In addition to the construction subsidies, Sweden, since 1954, has had a program of municipal *rental allowances* Every municipality decides for itself whether it wants to grant these allowances and how much they should be The state contributes from 42 to 75 per cent of the costs, depending on the size of the tax base in each municipality Mehr (1957) is of the opinion that these rent allowances are the most significant social insurance reform in recent years because they mean that "pensioners no longer need deny themselves decent housing for financial reasons because the total cost of rent is covered by the allowance" (p 6)

Community services to help old people who are independently housed are also supported in large part through the social assistance program in Sweden Since this type of assistance is not restricted to any definite form, it can be used by municipal social welfare offices to provide any type of service needed Thus it has been possible to develop extensive programs of household help for the aged and also to care for old people residing in their own homes or in nursing homes (Swedish Institute, 1956)

The low level of old age pensions in Sweden in relation to cost of living has been basic to the development of programs of rent allowances, construction costs and community services Another example of the relationship of the level of old age pensions to national housing practices and financing is found in the Netherlands Here where the basic pension of 1584 guilders for a couple is too low to meet even subsistence needs the government is aiding through subsidy programs, the building of flats especially designed for occupancy by the aged where an older couple can be maintained for 2700 guilders per year, as compared with 5000 guilders (plus an additional clothing allowance) required to keep them in an old age home, according to F H J Nierstrasz, a staff member of Bouwcentrum, Rotterdam (personal interview, 1957)

England affords a further example of the participation of the national government in the provision of housing and services for the elderly The Housing Acts of 1936 and 1948 made possible the granting of financial aid to local county councils or county borough councils for (1) building new structures for independent living (2) conversion of old homes, (3) building communal structures, and (4) offering community services to aid those living independently Through the National Assistance Act England also grants rent allowances to those old people whose incomes are so limited that, despite the receipt of a pension, their means entitle them to assistance grants The National Assistance grant is made up of two parts One is the scale rate, a level determined by Parliament with reference to the cost of living as being

a minimum subsistence payment, and, insofar as the pensioner's income falls below the scale, it is brought up to the statutory level The second part is the rent allowance and is considered of the utmost importance Rent controls operating since the war years have recently been abolished, and as a result, some rents have risen

Since 1957 about 500,000 National Assistance grants have been increased to take care of the advances in rents, the average increase being a little over 5 shillings (72 cents) per week In this way many old people have been able to retain their homes and meet increased rent charges

Government programs for housing the elderly are negligible or non-existent in France, Italy, and Switzerland, but West Germany is beginning to give some attention to this need In such cities as Berlin and Hamburg, high rise pensioner flats, usually without elevators, are being built with support from the federal government The money is loaned to private builders at a very low rate of interest with a 40- or 50-year amortization period Thus they can be offered at a low rental rate The first units built especially for old people after the war allowed only 32 square feet per apartment the size has been increased to 130 square feet now and it is hoped that, in the near future, funds and material will make it possible to increase the size to 172 square feet Chronic hospitals also are being built with the assistance of government funds to house the sick aged In Hamburg, for example a new three-story building has been added to a general hospital which serves as a central receiving point where all those admitted are screened to determine whether they should be cared for in the hospital or sent to an old age home

Other financial resources for housing the elderly have greatly augmented the housing supply and services for the aged in most countries since government interest and support of housing programs and community services have not excluded the participation of non governmental agencies No matter how much state and municipal subsidization has been available, it has never been enough in any country to provide adequately for the increasing demands. [illegible]

a number of European countries there has been a willingness of governmental agencies to give some financial support to the efforts of voluntary groups, the value of government expenditures has been considerably enhanced. [illegible]

telijke Dienstvan Sociale Zaken (personal interview, 1957) The Dutch federation for the care of old people, which is composed of all top level voluntary organizations concerned with the care of the aged, receives some financial aid from the government for its programs of research and for inspection of old age homes There are many church subsidized old age homes in the Netherlands, and a considerable number of the newest and most modern ones have been built recently by both Catholic and Protestant church groups The churches are also an important source of funds for making up the difference between living costs of the aged and their old age pensions and incomes The churches and voluntary groups, such as the Women's Voluntary Service, subsidize the community service programs, although some financial assistance often is provided by the government, especially the local municipalities The Red Cross provides some assistance for occupational therapy programs

The Netherlands is fairly typical of voluntary effort in other countries In England, for example, voluntary groups, upon application, may receive financial assistance from governmental sources for building new dwellings or converting old ones Normally, housing through voluntary effort is provided in one of these ways the formation by local groups of special hous

ing societies for the express purpose of establishing housing schemes for the elderly, the assumption by established voluntary agencies of the development of housing programs, and the adoption of housing as a part of the responsibility of the local old people's welfare committees Financial assistance which is available to these voluntary groups for the construction of new housing includes (1) a £10 subsidy per year for 60 years from the Exchequer for each new one bedroom bungalow or flat suitable for old people and (2) a maximum of 90 per cent of the capital cost of the scheme to be obtained as a mortgage through the local authority The repayment period is for 60 years at a current rate of 5½ per cent (Great Britain, National Old People's Welfare Council, 1956) For the *conversion of old houses,* three types of assistance are available (1) a 50 per cent improvement grant in a lump sum, (2) an improvement grant in the form of an annual subsidy for 20 years or (3) the obtaining of a mortgage Encouraged recently by the government, local housing societies have been especially concerned with the conversion of existing property because it can be used in accommodating old persons in their local neighborhoods The converted homes are frequently managed by volunteers, making it unnecessary to employ anyone beyond an overseer who may get only his living in payment Home help services are also provided in many English communities through the efforts and support of the local old people's welfare committees and through the Women's Voluntary Services These services are often in addition to those supplied by local municipal authorities, although the latter are permitted to give financial assistance to voluntary groups which provide hot meals to old people living at home or operate luncheon clubs where older people may obtain meals at nominal charges

To summarize briefly, financial support is provided by the federal and local governments of most countries This aid may be in the form of rent allowances, low interest, long amortization loans, or outright grants The housing may be built by municipalities, or the funds may be made available to voluntary groups or to private builders who build low rental housing Financial aid is available for new housing conversion, or the construction of old age homes and nursing homes In general, programs of conversion are the least popular with government agencies Financial assistance is generally available to voluntary groups also for providing various types of household help and care services To the government support of both housing and community services are to be added the funds raised by voluntary agencies the church, and labor organizations

F Payments Made by Old People

Government subsidization of construction of low rental housing and of old age homes is generally insufficient, however, to bring rentals within reach of pensioner incomes Hence, in several countries, notably Sweden, Denmark, and England, the authorities find it necessary to provide rent supplements or allowances

RENT ALLOWANCES FOR INDEPENDENT DWELLINGS

Since 1954 Sweden has had such state-subsidized rental supplements which are fixed in amount by the municipalities The state contributes from 40 to 75 per cent of the costs, depending on the size of the tax base in each municipality A rough average rental allowance in rural areas ranges from 150 to 180 kronor per year ($30–$36) for a single pensioner and 200 to 240 kronor ($40–$50) for a married couple In the cities they may range from 500 to 1000 kronor ($100–$200) or even higher (Tegner, 1956) The full rent allowance, established by the municipality, is payable if the pensioner does not earn more than 1000 kronor per year if single or 1500 kronor if married No form of retirement pension general family allowance, sickness

benefits or assistance received from relatives or others is considered as income in calculating the amount of rental allowance to be made to the pensioner (Swedish Institute 1956) If the income exceeds the limits set by as much as 400 kronor for single persons and 600 for couples the housing allowance is decreased by one third of the amount by which the income exceeds the basic 1000 or 1500 kronor, respectively If the income exceeds 1400 or 2100 kronor there is a further decrease amounting to two-thirds of the excessive amount

Although the granting of the municipal housing allowances to persons in receipt of retirement incomes is left to a local decision practically all Swedish municipalities have adopted the plan A number of cities have added additional sums so that the pensioners incomes meet with more than mere subsistence needs The following quotation by Mehr (1957) mayor of social affairs in Stockholm will illustrate how one large community has used the rental allowance provision to augment the income of its old people

> To begin with single persons are eligible for an allowance of 525 kronor and married couples 686 kronor This sum has nothing to do with the cost of the dwelling but is meant to help pay part of other living costs. The rent allowance has thus been used to improve the general standard of living for old age pensioners living in Stockholm In addition both single and married couples are entitled to a sum equal to costs of living in a dwelling including heating costs if any The upper limit is normally fixed at 1600 kronor (February 1957) but this limit is exceeded if the rent for a standard dwelling usually one room and kitchen happens to be higher Rent allowances are subject to an income test but are not reduced until a single person makes more than 1000 kronor a year and a married couple 1500 kronor A single pensioner in Stockholm without any large income of his own thus has his rent paid for him by the pension in addition he gets 2675 kronor to pay for other living costs Of this sum about 2150 kronor is represented by the national pension and 525 kronor by the municipal rent allowance The [rent] allowances mean that pensioners no longer need deny themselves decent houses for financial reasons The actual cost of housing is covered by the municipal rent allowance. As a result pensioners are not compelled to find accommodation in pensioners homes but can compete with everyone else for the dwellings available on the housing market [pp 5-6]

The pensioners' homes offer accommodations at rents fixed to cover the actual costs of operation But since rental allowances usually cover the total rent there is no disadvantage to the occupants To qualify for admission into a pensioners' home the person must be receiving the national old age pension and either lack a suitable dwelling or the possibility of acquiring one by his own efforts It is intended that the pensioners' flats are to be rented to persons having the least income

It might also be pointed out that the system of rent allowances has encouraged private organizations and institutions to build dwellings for the aged since they can count on the municipal rent allowance which makes it possible to charge rents that will cover the costs of operation

Denmark like Sweden, has taken steps to help cover rent payments In 1937, by an amendment to the Danish National Insurance Act, a plan of state subsidies was established for the operation of dwellings erected or acquired by local authorities to accommodate old age pensioners (Danish Ministry of Labour and Social Affairs, 1953) Under the amended Housing Aid Act of 1951, the state pays one half of the annual deficit incurred by the local authorities in operating approved old age pensioners' flats This rule applies automatically to all pensioners' flats erected after July 1 1951, and upon application to local authorities can be applied to those constructed at an earlier date

The flats are rented to pensioners who are in difficult situations—financially or otherwise The rents of the flats are fixed at amounts somewhat below the rate paid by pensioners in ordinary one- and two-room flats The pension payable to those

living in these low rental flats however, is reduced by about 4 per cent They have thus little, if any, economic advantage over pensioners living in ordinary flats Nevertheless the flats are popular because they are more modern and comfortable than the ordinary ones that can be rented at a comparable cost

Some concern has developed in Denmark about gathering the old age pensioners in special housing projects, since it tends to isolate them and impairs their opportunity for finding occasional odd jobs with which to supplement their incomes To meet this criticism, the 1951 Housing Aid Act provided that old age pensioners in economic need or other difficult situations could receive a subsidy for rent of accommodations in ordinary non profit housing projects which had been erected subsequent to July 1, 1951 The subsidy reduces the rent to the level applying to old age pensioners' flats

England likewise provides rent subsidies to help old people of low income meet the cost of living (Rowntree 1947) The Parliament of 1940 established supplementary pensions for old people and widows the cost of which is borne by the Exchequer and administered through the regional offices of the National Assistance Board For the year ending December 31 1957 the National Assistance Board reported that 978 000 allowances were being paid to supplement retirement pensions The supplements are granted only to persons whose incomes are too low to meet their needs (approximately 25 per cent of old age pensioners) To the extent that a pensioner s income falls below a subsistence minimum it may be made up by an assistance grant, and to this is added an allowance for rent The amount of rent allowance depends upon the general rent levels of the locality and the recommendations of the local advisory committee In most instances the rent is covered in full In applying the needs test many resources are left out or taken into account only in part The exemptions include (1) the earnings of sons and daughters living in the household of the parent (although it is assumed each makes a contribution to the household), (2) the first 10*s* 6*d* ($1 50) a week of superannuation payments coming from sources other than the Exchequer (3) the first £375 and interest on it of war savings Additional capital does not disqualify the pensioner for a supplementary pension unless it exceeds £400 and then only on a sliding scale in relation to increasing amounts of capital If the pensioner owns the house in which he lives its value is disregarded entirely, and an allowance for the mortgage interest, etc is made in place of a rent allowance

In the Netherlands where practically all dwellings constructed after the war were subsidized by grants either for building costs or for operating costs, rents have been kept at reasonable levels In the case of aged couples who have incomes lower than 2520 guilders per year, or single persons whose annual cash income is below 1640 guilders a rent subsidy of 100 guilders per year is made available if they live in postwar houses or in institutions

In brief it is obvious that these countries consider the principle that all old people should maintain their own households as of such major importance that far reaching government programs of financial aid have been devised to insure that pensioners will have the means to live independently if they wish These programs also assist the voluntary and private organizations which provide non profit pensioner housing by insuring that the old person has sufficient income to cover rental charges

ALLOWANCES FOR COMMUNAL ACCOMMODATIONS

The payments old people must make for accommodation and care in old people s homes are also subsidized by the state With some modification the municipal housing allowances in Sweden apply to persons living in an old age home so that the older person is not called upon to pay

beyond the limits of his income (Swedish Institute, 1956) For example, in Gothenburg the fees at the two most modern old people's homes are set at 6 70 kronor per day ($1.30), which makes it possible for the resident to pay them out of his old age pension and still have a sum left over for pocket money (Gothenburg Municipal Executive Board 1957) It might be noted here that applications for admittance are handled on the basis of need and not according to income or property

In England, where local authorities are charged under the National Assistance Act of 1948 to provide residential accommodations for any old person in need of care and attention, the subsidy scheme has been used to some extent by local authorities to build homes themselves But to a larger extent the authorities have used [illegible]

of residents less the amount they can pay for themselves (Shenfield 1957) Recently local authorities have overtaken voluntary bodies in the number of dwellings built or converted for group care of the elderly Where local authorities pay for maintenance of pensioners in voluntary homes the amount is usually based on the actual cost If the resident can pay the full charge which amounts on an average to between $7 50 and $8 25 per week, he is expected to do so Otherwise, he pays in proportion to his resources and the difference is made up by a grant from the National Assistance Board But, no matter what the cost of accommodation, the pensioner is always left a certain sum laid down by regulation as personal pocket money A similar plan is carried out in homes operated by local authorities where the average charge is about $10 per week. This is a higher figure than for the voluntary homes because clothing and other items are not included in the charges made by voluntary groups

As with independent housing attempts are made to assist old people to obtain the kind of accommodations they need—in this instance, residential or communal care The means used vary from the payment of special subsidies made directly to the individual to the fixing of rent rates at a level old people can pay from their regular pensions, with the operational deficit made up from public funds

In summary, the social policies which have been established in the last several decades by the countries of western Europe and the British Isles reflect a full cognizance of the needs and rights of older people Practices have been instituted to make possible the enjoyment by the aged of these rights and privileges Government, private enterprise, and voluntary agencies are sharing with the old people in attaining an assured place in the community, either as an independent householder or as a member of a communal group All effort is directed to helping the aged person to meet his needs as a self supporting citizen and to remove the taint of charity from the social assistance which may be required to assist the individual to attain this status

III Concepts and Principles in Housing the Aged

From their larger experience with the problems of housing relatively large numbers of old people, the Scandinavian countries and England have achieved the solutions to some of the most difficult questions confronting the United States today in its early attempts to develop a large-scale program of housing for the aged Out of practical experience and from the results of simple survey studies of the needs and wishes of older people, these foreign countries established national policies and defined a clear-cut set of principles to guide communities in the planning and constructing of old age housing

Reference has already been made in this chapter to a number of social concepts on which the housing principles and policies are based These may be stated briefly as follows

1 It is in the best interests of the economy and social health of the country to provide old people with living arrangements especially suited to their needs
2 Industrialized society because of its influence on the breakup of the generations must assume some of the responsibility for the shelter and care of the aged previously supplied by the family
3 The old age group has the right to its proportionate share of the goods and services available to other age groups in the population
4 Mental and physical health of older people are promoted when the aged are privileged to retain active membership in the life of the community

In Sweden a housing policy committee appointed by the Swedish minister of social welfare took the following position "In the first place and to the largest extent possible measures for the care of the aged should aim at assisting the aged by all available means to live independent lives in their homes as long as possible without excessive personal strain" (Ulrikoson, 1958 p 1)

Mehr (1957) has described in some detail the policies followed in the city of Stockholm which are the same as those subscribed to on a national basis

> The goal of old age assistance in Stockholm is to provide conditions making it possible for old people to enjoy a free and independent life to the same extent and in the same social forms as younger and middle aged people enjoy Essential components of this goal are of course economic security dwellings and medical service We also need an open service which can give the aged occasional help and do odd jobs for them Further we must try to abolish or prevent the isolation which so easily becomes an accompaniment to old age in a modern society Old and lonely are alas two words which are only too often linked together and rightly Various measures designed to improve the old person s contentment with his life must therefore be regarded as important factors in modern old age assistance [pp 1–2]

The English likewise have taken a broad overview of the housing for the elderly In *Housing for Special Purposes* (Great Britain, Ministry of Local Government and Planning 1951) the following statement is made

> The ultimate object of all housing activity is to give the opportunity of living a full and happy life in healthy and congenial surroundings For older people it means that accommodations should be provided which enable them to take their part in the life of the community Elderly people with their greater freedom from family cares can render valuable service to the community in which they live [p 6]

The most common dictum on housing the aging heard everywhere in England (and also in the Netherlands and the Scandinavian countries), is that the elderly should live in their own homes as long as possible because it is more economical for the state and because the old people are happier Admission to an old people s home should be a last resort (Moss 1957) Currently however this policy is under question because it may mean that old people are kept at home under circumstances where they cannot be properly cared for except by an unreasonably heavy burden on a family with perhaps adverse effects on young children Also it may be more expensive both directly in the cost of buying services and indirectly in absorbing scarce personnel

With these objectives in mind an examination of the various types of independent and institutional housing that are being built in various countries will illustrate the means employed to achieve the stated goals An understanding of the social values of a country and a knowledge of the housing principles based on them make it relatively easy to predict the policies that will be adopted in consideration of such specific and major questions as uses of independent and institutional homes, size and site of housing developments services to be included with housing special design features needed and programs to meet the social needs of residents

A *Homes versus Institutions*

In the United Kingdom the Netherlands and the Scandinavian countries where family responsibility for the older generation is declining and where, although it may still be a legal requirement the law is not enforced (in England it is no longer [illegible] s [illegible] o

for those [illegible] maintain their own homes Institutions are reserved for those who are so frail or disabled that they cannot manage a household any longer or who are so sick that they must have constant medical attention Effort is expended in creating a homelike atmosphere in the institutions in an attempt to make them more acceptable substitutes for independent living and family relationships

TYPES OF ACCOMMODATIONS

Pensioners flats or apartment buildings are the most common forms of independent accommodations in countries that have housing programs for the elderly As a rule these buildings are from two to four stories high Entrance to each flat is gained directly from the street or in the case of upper floors from a balcony The flats are usually built in blocks and may include such central features as heating assembly halls kitchens craft rooms laundry and bathing facilities Although each block of flats has a superintendent (usually a trained nurse in Sweden and Denmark) who assists the occupants in cases of emergency and illness complete privacy and independence of action can be maintained by the residents

Another type of housing which is seen more often in Holland and England than in the Scandinavian countries is the small cottage or motel type apartment In the Netherlands these are often interspersed in short blocks or distributed among high rise family apartment developments In England the cottages are sometimes designed as an integral link in the attached dwellings built for younger families, in other instances they are grouped together around a common square or garden And in some housing developments (estates,' as the English call them) the cottages are scattered through the property There is, as a rule, a superintendent in charge whose function is that of rent-collector and liaison between renter and local authorities Services include heating community club room and gardening

In the Netherlands is to be found a special type of cottage development—the *hofje* —already mentioned as a traditional form of housing first built by seventeenth-century Dutch merchants for their retired servants and workers The inclosed court of the *hofje* offers a special charm Located, as many of them are, in the hearts of large cities they seem quite remote from the hustle and noise outside their walls The attached cottages are arranged with their backs forming the solid outside walls of the square and their doors opening on the friendly central court The *hofje* usually includes quarters for the supervisor (manager) but otherwise there is often no central service Sometimes, however, there are, especially in modernized units such central services as heating kitchens, etc The new *hofjes* of today are almost exact duplicates of those constructed several centuries ago except that modern conveniences are now included and sometimes meals, laundry, and home help services are offered

Intermediate between completely independent housing and the communal old age home is the center system' A large communal building—the mother home—has small houses built around it In case of temporary illness frailty, or loneliness, the mother home provides the occupants of the cottages with such services as hot meals cleaning heating laundry, and occasionally some nursing care When the residents become too frail or lonely, they move into the central home

Institutional or congregate living arrangements range in all the countries studied from the remodeled large old

houses, through the institutions and the church or other voluntarily supported homes of the past, to the most modern of buildings conceived to preserve the dignity and independence of the old person These institutions all offer central services, including dining Many, but not all, include medical and infirmary care Some of the ingenious architectural features developed to reduce the institutional character of the old age homes will be discussed in a later section

The large old people's villages which have been built in several countries deserve a special note because, in spite of the fact that experience has made them more and more unpopular in Europe and the United Kingdom, there is evidence that builders and social planners in the United States are moving toward the construction of similar developments The principle of the village is to provide for all the needs of the elderly Thus the village includes a number of types of accommodations so that, as the individual becomes progressively more feeble, there is a living arrangement where the needed degree of care is offered The villages usually include such central features as a dining hall, church, post office, and recreation center, and, if far removed from a community, a small shopping center A number of these large villages have been in operation since the 1920's, and a study of them is useful in determining whether they constitute a desirable form of housing arrangement for the aged (Donahue, 1960)

PROVISIONS FOR PRIVACY

Privacy has come to be recognized as one of the major attributes of good housing for older people Dr Berggren, of Sweden, comments that every old person has the right and necessity to be alone as opposed to being isolated The provision of cottages, flats, apartments, and maisonettes built for single or two person occupancy has as a primary objective the preservation of privacy In the communal homes there is also increased effort to insure that each individual has a reasonable degree of privacy The newer buildings have private rooms for single persons and couples Older buildings are being remodeled to provide single rooms or to reduce the size of the large wards to accommodate four to six persons in place of fifteen or twenty In some instances half partitions are used, especially in those units where persons live who are receiving nursing care Even in the old time institutions which do not lend themselves to remodeling, privacy is provided by hanging curtains permanently around each bed space Although such an arrangement seems cramped and airless, the occupants when asked by the writer how they liked the plan, replied that they liked it very much indeed because they had a place of their own, away from the prying eyes of their neighbors

There is also a tendency to reduce the amount of common living space provided in the communal homes and to distribute the square footage among the living quarters of the residents Little use is made of common space generally, since the residents prefer to sit and to entertain their friends in their own rooms rather than in a public room In order to make the single room appear to have a maximum of privacy, a small vestibule is recommended Water closets are installed in most apartments, and in the newer buildings there are also some private baths In older buildings bathtubs are sometimes installed in the kitchens

The notion of privacy is expressed outside the dwellings by providing small yard garden spaces, often shielded from the adjoining garden by a fence or solid wall In the Netherlands, where the one story row housing is common, each apartment has its garden opening off the living room to furnish, in good weather, an extension of space

INDIVIDUALIZATION OF ACCOMMODATION

As much value is placed on providing a homelike atmosphere which reflects the personality of each occupant as on pri

vacy One way in which this is accomplished is by permitting the renter to use his own furnishings Even in communal homes this is the practice although the individual may be advised on the suitability of pieces and helped to have old furniture refinished and re upholstered in suitable colors and fabrics Sweden has perhaps gone further than other countries in reducing the institutional quality of old age homes by using different colored and patterned wallpapers and textiles throughout the buildings gay scatter rugs (on non slip mats) a variety of small table lamps in place of overhead lighting a lavish number of plants and good pictures for the walls

B Size of Housing Developments

If there is a single trend with reference to the size of housing developments it is to keep them relatively small After early experiences with large old people s villages such as De Gamles By in Copenhagen or Riehler Heimstattan in Cologne each of which accommodates nearly 2000 persons it was concluded that the bringing together and isolation from the regular community of large numbers of old people is an undesirable practice In consequence most housing developments of all kinds are now kept relatively small.

In Stockholm on the basis of practical experience it is recommended that the ideal number of flats in pensioners' blocks be 100 This size is considered large enough to constitute a unity in regard to the staff needed to help the elderly dwellers and small enough so that the old folk cannot dominate but will naturally melt in with the other populations in the area (Mehr 1957 p 7)

With reference to the number of old people who should be accommodated in a single old age home there is some divergence of opinion In the Netherlands it is recommended that a home should *not* be built for less than 50 persons because it is not economical to operate for any smaller number At the upper limit, 300 places are set as the maximum number, according to F H J Nierstrasz (personal interview, 1957) Dr Berggren in Sweden, recommends that the optimum number of places in each home be from 30 to 40 Except in large cities where the homes may accommodate from 80 to 150 persons, the number of places in each separate home is as a rule not less than 18–20 and not more than 60 In planning new old age homes the number of places needed is estimated on the basis of 10 per cent of the number of inhabitants in the community aged 70 and over (Berggren 1958*a*) In the United Kingdom the recommended number is 25–40 people with 30 considered an ideal number If it is desired to accommodate more than 30 old persons at one site, additional b [illegible] 30 p [illegible] Min [illegible] *ning 1951)*

It should be pointed out however, that, although there is general agreement in most countries that on many grounds small homes are desirable for older people in communal care, there is not infrequently a gap between declared policies and actual *practice* In Stockholm for example there is a relatively new fourteen-story all purpose home for the aged In the United Kingdom in place of building to accommodate 30–40 persons, homes to accommodate 60–75 residents have been approved officially and constructed The increase in size is justified on the grounds that in the small homes staff is hard to get and keep, thus the small home is *often insufficiently* staffed With a larger staff for 60 residents, duties can be switched temporary absences of staff can be absorbed and the staff is more contented because they have more social life *In fact* to get and keep staff the wishes of the staff rather than the requirements of the elderly are given preference These are the practical considerations which tend to shape policies *despite* the best intentions

C Siting Old People's Housing

In the past, European countries and the United States made it a custom to locate homes for old people in remote spots ostensibly to shield them from noise and traffic Today there is a unanimity of opinion that this is not a desirable practice for a number of reasons First, it is against the wishes of old people themselves A number of surveys of old people's housing preferences show that they wish to live close to friends and relatives, shops, and other community services rather than in isolated areas In large cities, such as Stockholm, London, and others, where it is not possible to obtain land at permissive cost in the central part of the town, practice is opposed to principle, and new housing and conversion of existing dwellings are still located in remote areas There is, however, considerable objection on the part of old people to moving to the pensioners' flats built in the suburbs (Goldberg, 1959)

A second consideration is that when old people are moved into new housing located away from the area where the family members reside they lose much of the help and companionship their children provide In the Wolverhampton study (Sheldon, 1948), it was found that, although not sharing the same accommodations, family members often lived in such close geographical proximity that they shared their daily lives with one another and offered each other much reciprocal service Townsend (1956) likewise, in his study of the extent and content of the individual family relationships of old people in Bethnal Green, found that, of those living alone, three quarters of them saw at least one relative every day or every other day and received many services from them of a domestic nature Townsend, therefore, argues that social policies for housing should maximize these enduring aspects of family life by locating dwellings for old people in proximity to that of younger families Thus the younger and older generations need not share the same roof but can profit mutually from close association Shenfield (1957) points out an added practical advantage of this arrangement is that it is easier to convince old people living in a too large accommodation to move to a smaller and more appropriate one if the move does not entail going to a new district far removed from contact with relatives Where congested urban areas are being cleared and sites redeveloped at lower densities, local authorities are asked to give special consideration to enabling the old to remain in the neighborhood they know and where they have social connections and to keep them whenever possible near their families

Another principle in selecting sites for old people's housing which is closely related to the foregoing is that it should be integrated with normal housing in such a way that any appearance of an old persons' colony is avoided It is for this reason, in part, that the large retirement towns such as Whitly Village near London De Gamles By in Copenhagen, and others, are now looked upon with some disfavor In Stockholm, where only a modest number of pensioners' flats are built together in any one residential area old people have expressed some objections to living even in this degree of segregation It is largely for this reason that the government makes aid available to non profit builders for the provision of pensioners' units in ordinary apartment houses The Central Housing Advisory Committee of the Ministry of Local Government and Planning (1951) in England recommends that dwellings for the elderly be sited among ordinary housing developments but, in order to expedite the provision of some central supervision these dwellings may be grouped together up to twenty cottages, or they may be interspersed with family dwellings but arranged so that the cottages are within easy reach of one another

Finally, it is recommended that communal homes for the aged be located so that they are an integral part of the community The English Advisory Committee

on Housing (Great Britain Ministry of Local Government and Planning 1951) suggests that the hostels planned for those who are no longer able to manage a household be located in the same districts as the groups of old people s cottages and near the health centers of the public health authorities Thus a complete range of suitable accommodations for old people will be available to them in such a way as to insure that such changes as they have to make as they advance in years will be least upsetting to them (p 11)

Old people s homes are of course not restricted to the larger cities especially in countries where there is a legal requirement that all old people must be provided suitable housing by the local authorities The modern practice is to locate the old age home serving a rural area in a small village where the residents can easily mingle in the life of the community In other words although an old age home inevitably represents some separation of the occupants from normal residential living an effort is made to prevent their isolation from the community

The foregoing suggestions are those which have evolved out of a good many years of experience in a number of countries In all instances small projects as completely integrated with the community as possible are recommended as the most desirable practice It should however, be pointed out that large homes and the old age village in remote areas are still being constructed The newest old age home in Stockholm is a high rise building of fourteen stories in Oslo a thirteen story building has just been completed An announcement has recently been made (German Federal Republic 1958) of the plans for the first Old Age Village at Murnaw in West Germany It is to be built on a 30 000-square meter tract of land on the slopes above Lake Staffelsee in the foothills of the Bavarian Alps It is described as being in distinct contrast to the usual old age home because its inmates are to be given more individual care greater freedom of activity, and an activities program In spite of the glowing account of the opportunities for the old people to lead independent lives in one and two-room flats and of a research program to study the problems of aging one must still pause to consider the advice of those long experienced in operating projects involving the isolation and separation of the aged before accepting the proposed Murnaw Old Age Village with uncritical enthusiasm

D Medical Care and Housing

Medical care of old people living in their own homes is little different from that of other age groups The question is largely how medical resources are to be divided and whether special clinics and health programs for the elderly are to be developed Chapter vi indicates the extent of these kinds of services provided by various countries

The problem with reference to old age homes is however somewhat different and revolves around the question of what and how much if any, medical service is to be provided by the home, and where if full medical care is not provided such service will be obtained As already mentioned the old age home was traditionally a place where the indigent sick aged went for shelter and care until death There was thus established a societal expectancy that old age homes would offer life term care There is a lingering flavor today of this stereotype which especially in the United States, is confusing the adoption of clear-cut policies with regard to the amount and type of medical care to be included in the services of old age homes

HOW MUCH MEDICAL CARE?

Sweden has adopted a national policy which delineates more clearly than the provisions of other countries the roles of the

... Social and Medical Boards have agreed that old persons who are sick

C Siting Old People's Housing

In the past, European countries and the United States made it a custom to locate homes for old people in remote spots ostensibly to shield them from noise and traffic Today there is a unanimity of opinion that this is not a desirable practice for a number of reasons First, it is against the wishes of old people themselves A number of surveys of old people's housing preferences show that they wish to live close to friends and relatives, shops, and other community services rather than in isolated areas In large cities, such as Stockholm, London, and others, where it is not possible to obtain land at permissive cost in the central part of the town, practice is opposed to principle, and new housing and conversion of existing dwellings are still located in remote areas There is, however, considerable objection on the part of old people to moving to the pensioners' flats built in the suburbs (Goldberg, 1959)

A second consideration is that, when old people are moved into new housing located away from the area where the family members reside, they lose much of the help and companionship their children provide In the Wolverhampton study (Sheldon, 1948), it was found that, although not sharing the same accommodations, family members often lived in such close geographical proximity that they shared their daily lives with one another and offered each other much reciprocal service Townsend (1956) likewise, in his study of the extent and content of the individual family relationships of old people in Bethnal Green, found that, of those living alone, three quarters of them saw at least one relative every day or every other day and received many services from them of a domestic nature Townsend, therefore, argues that social policies for housing should maximize these enduring aspects of family life by locating dwellings for old people in proximity to that of younger families Thus the younger and older generations need not share the same roof but can profit mutually from close association Shenfield (1957) points out an added practical advantage of this arrangement is that it is easier to convince old people living in a too large accommodation to move to a smaller and more appropriate one if the move does not entail going to a new district far removed from contact with relatives Where congested urban areas are being cleared and sites redeveloped at lower densities, local authorities are asked to give special consideration to enabling the old to remain in the neighborhood they know and where they have social connections and to keep them whenever possible near their families

Another principle in selecting sites for old people's housing, which is closely related to the foregoing is that it should be integrated with normal housing in such a way that any appearance of an old persons' colony is avoided It is for this reason, in part, that the large retirement towns, such as Whitly Village near London, De Gamles By in Copenhagen, and others, are now looked upon with some disfavor In Stockholm, where only a modest number of pensioners' flats are built together in any one residential area old people have expressed some objections to living even in this degree of segregation It is largely for this reason that the government makes aid available to non profit builders for the provision of pensioners' units in ordinary apartment houses The Central Housing Advisory Committee of the Ministry of Local Government and Planning (1951) in England recommends that dwellings for the elderly be sited among ordinary housing developments, but, in order to expedite the provision of some central supervision, these dwellings may be grouped together up to twenty cottages, or they may be interspersed with family dwellings but arranged so that the cottages are within easy reach of one another

Finally, it is recommended that communal homes for the aged be located so that they are an integral part of the community The English Advisory Committee

these units usually follows evaluation in a geriatric hospital The National Corporation for the Care of Old People has established a number of these rest homes

4 *Long stay annexes* for the irremediably sick These are designed to accommodate the chronically ill and are therefore technically a part of the medical care services (see chap vi) as for example the Geriatric Unit of the Cowley Road Hospital Oxford, or the Geriatric Hospital of the Sunderland Area Hospitals

The housing of the mentally confused old people is a problem still of concern to the English (and all other countries, for that matter) In 1950 the Ministry of Health (1950) recommended that long stay annexes be established for patients without marked behavior disorders as distinct from the disturbed types The annexes, it was suggested might be associated with mental or general hospitals or with hospitals for the chronic sick although it would be preferable to locate them outside the curtilage of a mental hospital

The Netherlands Ministry of Housing and Building recently supported the preparation and publication of a report prepared by Bouwcentrum (1958) on the subject of nursing homes for the mentally infirm old people A special committee of professional people assisted Bouwcentrum in this study and recommended that the mentally infirm (senile dementia lightly depressive and inactive, alcoholics, mentally deficient epileptics etc) should be provided separate homes and should not be cared for in a psychiatric institution or in a separate department of old age homes or institutions serving the mentally fit aged The report says that "among other things it has been precisely the careless mixing of totally different categories which

has led to less desirable conditions Moreover, the category in question requires a specific form of nursing which—partly for psychological reasons—can hardly be combined with the care of mentally fit old people Although it is recommended

apacity for 150 per

sons it is emphasized that patients should be accommodated in units serving no more than 12 persons Detailed building plans are a part of this report (See chap vii for further discussion of this type of accommodation and other arrangements for the senile aged)

FINANCING MEDICAL CARE IN HOMES FOR THE AGING

One p oblem wh

cost of building and equipping medical care or hospital units and of employing a skilled staff In fact, this cost, as much as the shortage of professional personnel, is a major determinant of the medical care policies recommended

In Sweden, where virtually all hospitals are maintained at public expense (in 1954 the public subsidized hospitals had places for about 100 000 patients while private hospitals had only 2000 places), it is logical to follow a policy of offering hospital service to old people in the regular hospitals as opposed to diverting staff and equipping expensive units for old age homes (Tegner, 1956) Since the basic principle is that all citizens are entitled to the best possible care at low cost, no one is expected to be denied adequate care for lack of funds Aged persons who have chronic illnesses of long duration will be cared for in chronics' homes, but the cost will usually be covered by benefits or will be made up by public assistance

The United Kingdom likewise through the National Health Service Act, makes hospital care and the services of specialists available to people of all age groups The hospitals in a number of areas have established special geriatric units where care on a long term basis is available The emphasis in these hospitals is on rehabilitation of the patients and in making the hospital service an integral part of the total community program for the aged Such services make unnecessary the inclusion of

shall have the same care in the same hospitals and under the same law as all other citizens Dr Berggren (1958*b*) has expressed the Swedish position as follows

> We are now of the opinion that an old person when he gets sick shall have the same opportunity of a doctor s help in the ordinary hospital organization as any other citizen But we have a great shortness of hospital beds and nursing personnel so that for the present and in some provinces for another ten years, we are obliged to organize home care and sick care to a certain extent in old age homes [p 2]

It is clearly recognized by Dr Berggren and others that the shortage of medical personnel already handicapping hospitals in their effort to care for the long term ill aged makes it *utterly impractical* to assume that the medical service afforded residents in hundreds of old age homes goes beyond mere custodial care In the large cities, of course where the personnel shortage is less acute, the picture is somewhat better In Stockholm, for example, there are five homes which combine a nursing home with an old age home and offer full scale medical care and rehabilitation services (Dahlstrom, 1956)

In the Netherlands, with the new trend toward offering two types of housing—the independent dwelling for those able to maintain a household and the old age home for those who need nursing care—hospital type care is introduced into nursing homes *and excluded from old age homes*

Although considered atypical and undesirable by the Dutch a large home in The Hague illustrates the range of care available in one of the new types of the "all round care" homes For the most able, there are small cottage apartments built adjacent to the large central building The old people occupying these cottages receive no medical or nursing care except for temporary illness For those who need continuing medical service there are several types of accommodations within the central building The first of these is designed for occupancy by a couple of which one member needs continuing medical care and is a self-contained apartment consisting of living sleeping room and kitchen-dining room A balcony offers extra space in good weather For single persons who are still largely able to manage for themselves there are single room accommodations and, *finally*, for those who are so ill that they need continuous hospital type care there is a hospital wing Although the building includes an assembly hall, craft rooms, and recreational facilities it has the character of a medical institution rather than that of a home, an impression augmented by the location of the morgue in the wing where the more able residents are housed The building of this type of "all round care" home is being discouraged also *in other countries of* Europe as an undesirable practice

In England and in a number of other countries the trend is to provide a variety of housing accommodations for those who are too frail or too ill to manage households for themselves These can be *classified as* follows

1 *Residential homes for* the ambulatory who can look after their personal needs but who must have housekeeping services and some general oversight Only temporary illness of a few days duration can be cared for in these homes
2 *Halfway homes* associated with geriatric hospitals for those people who need convalescent care after hospitalization and before they return to their homes and also for those who need longer term care while they undergo physical and mental rehabilitation before discharge to their homes Actually there are very few of this type accommodation and it is predicted by various leaders that there will not be much development in this direction

   The Guilleband Committee in its study of the structure of medical care condemned the halfway houses as intermediate accommodations for the long term ill in the belief that persons ordinarily cared for in them are rightfully hospital patients
3 *Rest homes* for those who do not need hospital care but do need constant attention and help of a simpler kind Admission to

The external architecture of these English cottages reflects the traditional designs of the region where they are located Usually of brick fireproof construction they form neat rows of houses often in a garden setting

In Sweden pensioner flats are typical of the public independent housing built in that country as well as in Denmark Switzerland and West Germany As a rule the pensioner flats consist of one room and kitchenette for single persons and one room and kitchen or one room sleeping alcove and kitchenette for two persons (married couple sisters etc) The recommended floor space for new flats is 260–330 square feet for one person and 320–70 square feet for two persons Kitchens and kitchenettes are fitted with electric ranges cupboards and shelves are readily accessible and refrigerators are installed in the newest kitchens Each flat has a lavatory with hot and cold running water and a water closet There are no private baths but ten to twelve flats share a common bathroom which is generally located in the basement and is large enough to permit the bathers to receive assistance when needed Some flats have a bathwoman on duty at specified times to help the residents bathe Bathtubs and water closets have grab bars (Mehr 1957)

Some ordinary apartment houses in Sweden also have flats especially designed for invalids These flats generally consist of two rooms a kitchen and a windowed hall The total floor space is about 860 square feet Doorways and corridors are large enough to permit the use of wheel chairs Special attention has been given to the design of the kitchens The space beneath the sink is open so that the housewife can use it while sitting down wall cupboards are low enough to be easily reached from a wheelchair Bathrooms are larger than usual and are equipped with stand-off grips horizontal bar supports, and handholds around the toilet. Other aids have been built into wardrobes closets doors and windows. Electric switches are easily reached and activated Built in features include linen closet clothing rack, wardrobe and ironing boards According to Mehr (1957), this type of flat and these special features have given most favorable results when used for old people

The pensioners' flats in Copenhagen like those in Sweden are grouped in several centers throughout the city Their design has been described as follows (Københavns Kommunes Socialdirektorat 1948)

> In planning these centers Copenhagen has chosen a mixture of two building systems central corridor houses and ordinary staircase houses The first type is especially intended for the oldest and weakest inhabitants and has lifts and garbage chutes
>
> The flats which are situated in detached [illegible]
>
> as hot and cold water Those of the occupants who cannot or who do not wish to cook their own meals may buy their dinner at a very moderate price Most of the centers have bathing departments for common use and a feast room gratuitously placed at the disposal of inhabitants for celebrations of family as e g golden weddings etc
>
> The flats for married couples consist of two rooms of a total area of about 46 square meters and those designated for single persons have about 37 square meters and consist of one room and usually an alcove Every flat has a kitchen a lavatory a hall with a built in wardrobe (p 13)

The special housing for old people in Holland like that in Sweden includes experiments with various design features A number of manuals have been issued on housing the aged (Bouwcentrum 1955 1958) based on careful study of old people s needs with reference to their status and physical and mental health There is an emphasis on privacy and many of the residential (communal) homes in the Netherlands (mandatory in the province of Frisia) have a water closet in every room or apartment and many of the rooms include kitchenettes

In general all plans for pensioners

hospital units in the old age homes It must be admitted, of course, that the shortage of hospital beds often makes it necessary to nurse older residents in a home Also, as more elderly and infirm persons enter homes, the need for nursing care may be extended, and "sick bays" are beginning to appear more often in communal homes The National Health Service scheme, of course, entitles old people living independently to care by a doctor and to glasses, dentures, surgical appliances, and prosthetic devices The patient pays certain fees for these services, but repayment can be obtained from the National Assistance Board if the recipient is too poor to pay himself

In the Netherlands there exists a voluntary sick insurance scheme which more than two thirds of all the aged use The premium is very low Almost all residents of homes have this type insurance, which entitles them to the same health services and care as the general sick funds

E Design and Special Features

A number of European countries have carried out practical experiments with different designs for independent dwellings and for old people's homes As a result, they have developed standards that have gone through a fairly extensive process of evaluation and have established some guide lines for future construction and design—in general, economy of size, easy maintenance, and a homelike quality

INDEPENDENT DWELLINGS

The *Housing Manual, 1949* and its *Supplement, 1951*, published by the Ministry of Health (1949, 1951) in England, list the recommended designs for accommodations to house able bodied aged persons capable of looking after themselves In summary they are as follows

1 Accommodations should be provided in self contained dwellings of either one- or two story cottages or cottage flats or on the lower floors of blocks of flats
2 The units should be comprised of a living room, double bedroom entered from living room or hall, working kitchen and combined bathroom and water closet The bedroom may take the form of a bed recess with a separate window, in which case an additional single bedroom may be provided
3 The recommended minimum sizes for rooms are (in square feet) living rooms 140-60 living room and bed recess 230-50, double bedroom 120 (minimum), and single bed room 70-80
4 Over all sizes of dwellings are for two persons 450-550 square feet, for three persons 550-650 square feet
5 Special features include front and back doors sheltered to prevent drafts good *thermal insulation, easy access to fuel from* within the house, clear space on either side of the beds handrail to the bath, stairs if any easy to climb with handrail, fireplace in main bedroom if a separate room solid fuel heater in the living room heated towel rail in bathroom, living room with sunny exposure, bay window or veranda whenever possible, sills of windows low enough to see out of from chair or bed, water closets and bathroom doors opening outward, communal garden maintained in front of dwellings, private garden plot of personal cultivation in the rear and central heating prepared for large blocks of flats

A typical plan for a two person flat having a bed recess in place of a bedroom has the following specifications

Living room	14 3″ × 11′3″
Bed recess	9 × 8 3
Working kitchen	7 9 × 7 6″
Bathroom with water closet	7′ × 4′

A typical two person one bedroom flat has approximately the same dimensions except that the bedroom is 11 feet 3 inches by 10 feet with the bathroom and halls correspondingly larger

Ancillary accommodations are needed for the warden's flat and office a guest apartment or two, storage space, and heating plant, and, if central dining or cooking is a feature, a kitchen and some staff quarters are included

1 The buildings are of fireproof construction and often made of brick No pensioners rooms may face north
2 Construction is kept low but frequently includes some sections of two story height
3 Most are built for small numbers of single men and women Very few accommodations are provided for couples
4 Single rooms must have a minimum furnishable floor space of 10 square feet
5 Each room must have a small anteroom with a hot and cold water basin coat rack and built in wardrobe
6 Two water closets are provided for each 8 pensioners and bathrooms with foot baths are available in every corridor
7 Common rooms sitting and recreation rooms dining rooms and small coffee kitchens are on each corridor for the use of residents auditoriums are provided for religious and other types of meetings
8 Space for the administration and operation of the home also includes kitchen laundry offices medical treatment rooms nurses rooms and if the staff lives in bedrooms and sitting rooms

There are no fixed types of plans for these homes The design is worked out in each individual case on the basis of the type of community nature of the terrain and part of the country The architect meets with the community planning committee and arranges for representatives to visit several homes to learn at firsthand the problems and their solutions Following this experience the architect and committee complete the plans which include not only the design and standard equipment of the home but the furniture textiles art objects pictures plants etc This type of individualized planning accounts for the inherent charm of the modern Swedish old age homes

A number of special features contribute to the coziness and homelike atmosphere that do not appear in the list of minimum standards One of the most effective in reducing the institutional character is the treatment of corridors A number of devices are employed to achieve short corridors with an open character One method is to provide visual contact in the corridor at all times with furnished areas Small sitting rooms may be used to break the length, the ends of the corridors may be made wide enough to accommodate some furnishing along one side without jeopardizing the safety of the residents Often one side is made of glass thus permitting a view of the garden and terrace Other homelike features include provision of several small sitting rooms to encourage more family like groupings of the residents, several dining rooms in place of one large room are also used to promote intimate interpersonal groupings Floor plans are arranged so that the rooms of the residents in each part of the building are grouped for easy access to a coffee kitchen and small sitting room Open fireplaces fitted with gleaming copper pots good inexpensive Swedish furniture, colorful textiles and good art objects all add a personal quality to the building Outside there is usually a terrace and inclosed courtyard which offers protection from wind and the eyes of the passerby A fountain small pool shrubbery and gay lawn furniture in the summer add their touches also

An ingenious architectural design which encompasses the principles of intimate groups privacy, and independence is to be found in the old age home Jarnbrottshemmet in Gothenburg It was opened for occupancy in 1956 and consists of two star buildings (each has a small central hall from which three wings lead) built side by side and connected only through the household department in the basement floor Every star has three floors and every floor has thirteen rooms—twelve single rooms and one double room Each floor forms a closed unity for the fourteen old persons living there and has its own sitting room dining room coffee kitchen bath room, and balcony The use of a star with 'three arms' avoids the long corridors found in the more traditional old age homes Rooms are furnished by the Social Board but each person who wishes to may bring his own furniture or pieces of it An

homes emphasize compactness and special design features to make maintenance and living easier Most of these accommodations are probably too small in scale to suit the American taste, but they are not too different from what the United States has been able to provide through its program of public housing For example, one of the newest public housing developments, the A Gideon Spieker Terrace in Toledo, Ohio, built in 1958, has 44 one bedroom units (for two person occupancy) of 530 square feet each, and 6 efficiency units of 325 square feet each Equipment for these units includes refrigerator, electric range, cupboards, gas burning space heater, individual water heater, bathtub with built in seat and handrail, water closet, and lavatory The preservation of privacy, independence, and self support are the prime and the most valued characteristics of these designs for independent dwellings, and most old people seem to prefer to sacrifice size to any one or all of the others

COMMUNAL HOMES

Specifications for residential hostels (old people's homes) are also given special attention in *Housing for Special Purposes* (Great Britain, Ministry of Local Government and Planning, 1951) with the following standards

1 The building
   a) Not more than two stories high
   b) First floor—communal rooms, dining room kitchen residents' bed sitting rooms and warden s apartment
   c) Second floor—bed sitting rooms for residents
   d) Communal rooms should face south or west and afford view of garden
   e) Bed sitting rooms should face west south or southeast so each one will get some sunlight every day
   f) Rooms for single men single women and couples should be mixed rather than placed in separate wings
   g) If rooms are placed on both sides of a central corridor, the corridor should have natural lighting and ventilation
   h) All rooms halls and passages should have central heating
   i) Communal rooms should have open fires in addition
2 Bed sitting rooms
   a) Size single 140 square feet desirable 108 square feet minimum, double 180 square feet minimum
   b) Fittings and features wash hand basin built in cupboard with hanging space and shelves, electric fire, electric bell by bed, good central light plus a bed side lamp, good natural lighting
3 Communal rooms
   a) Dining room 15 square feet per person with small tables in place of refectory tables
   b) Common rooms 20 square feet per person
4 Bathrooms and water closets
   a) One bath to every 10 residents—to be used by either sex
   b) Two water closets to every 10 residents —separate for the sexes
5 Ancillary accommodations warden s office (130–50 sq ft), cloakroom with water closet and basin, kitchen with wash up larder storerooms linen room and laundry service elevator near kitchen, staff sitting room and lavatory accommodations, staff bedrooms and warden s apartment if resident small pantry with sink and electric kettle for use of residents small laundry and trunk storage for residents

The modern old age home in Sweden probably represents today's most advanced thinking in the design of old people's homes Sweden has been able to experiment with various types and features because the housing authorities there have been determined to find the most suitable and most homelike accommodations possible The architects have become interested and are beginning to specialize in the design of old people's homes

Some of the special features that are given attention in the design of the modern Swedish homes are outlined by B Boustedt, architect of Kungalv, Sweden, who designed and built 35 homes for old people during 1957 The general architectural features may be summarized as follows

lectures and group celebrations, television rooms and ordinary sitting rooms In addition these large homes have rehabilitation centers including occupational therapy Special staff personnel are employed to assist in developing these programs However, for the most part only a relatively small number of residents participate in these planned activities, preferring ap

out

here

upa

tional therapist with well equipped craft rooms and shops at her disposal no more than 10 per cent of the residents take part in the craft program according to Dr Torbin Geill, medical director of the town In other instances, where the old age homes do not cater to the sick and to those in need of rehabilitation even less activity is found Perhaps it is no mere accident that as is frequently true in our country the craft rooms are often just what appears to be left-over space in the basement turned into a hobby shop as an afterthought The residents do not find such space easily accessible or attractive and only a few are motivated to take part It may be that the idea of old people leading an active existence after retirement to an old age home is

the stereo-

it and

inclu

sion of activity rooms and intimate space for small group functioning and the employment of skilled directors of leisure programs will gradually bring about the change in attitude which the planners in most European countries are seeking

In the independent housing developments in England Switzerland the Netherlands and the Scandinavian countries there is usually included at least one building which is open to the use of residents free of charge A few of these are open also to older people living in the neighborhood but aside from the old people s clubs which are found to some extent in practically all countries now there are few comprehensive leisure time programs

Perhaps a glimpse of the possibilities for such programs in countries with social policies which permit the older age group to share equally with other population groups is to be found in the plan envisaged for Stockholm in the near future (Mehr, 1957) Each group of pensioner flats usually contains (1) an auditorium where lectures, plays, and films are offered and parties are held, (2) a snack kitchen, (3) small rooms for group gatherings, and (4) hobby rooms equipped with tools, looms, and sewing machines The city proposes to open these facilities to pensioners scattered in ordinary apartment houses 'The idea is to let the pensioners get together in a friendly informal atmosphere, where they can talk, drink coffee, do handwork, play cards, listen to lectures, watch films, or hold social evenings ' In addition to the leisure-time space in the pensioners' flats, the city of Stockholm is trying to establish a network of rooms and halls throughout the city for the leisure use of old people by encouraging parish homes and the city's youth recreation centers to set aside space for this purpose Behind the provision of space, there is an effort to encourage the pensioners to form clubs and draw up their own programs

In the Netherlands there is already a similar policy in operation Day centers which are open daily offer organized programs and provide space for informal socialization More of these types of programs are planned in recognition of the need to provide activities both within the old age institutions and in the community

G Administration and Personnel

The character of the administration and the personnel requirements for successful management of a housing project reflect (1) the type of housing (whether individual dwellings or communal), (2) the philosophy held with reference to the rights and roles of older people in society, (3) the nature of the program offered, (4) the adequacy of funds for operation, and (5)

attempt is made to vary the furniture, curtains, carpets, and wallpaper so that no room is like another The rooms each have a small entry hall with washstand and cloakroom There is central heating provided by the district heating center The kitchen serves all six dining rooms in the two buildings Two rooms in each building are set aside as medical treatment rooms for the care of temporarily ill residents There are also hobby rooms for weaving and woodworking, an auditorium for entertainment, and a small chapel for private devotions

The "all-round" plan for residential care, although not in accord with current Dutch policy, is being tested in the Netherlands Moerwijk is a typical example It is located in a southern suburb of The Hague and is operated by the Municipal Welfare Service The architectural design is considered an experiment in combining service flats with self contained flats and nursing department The central building consists of a number of wings built in the shape of an H and varies from two to four stories in height Altogether the project houses 298 residents and has room for five guests and six staff persons The wing consists of 14 bed sitting rooms intended for one person occupancy each These rooms have floor space of 118 square feet Other wings have flats for couples, and the floor space varies from 260 to 380 square feet The smaller flats contain a living room and bedroom, the larger ones have an added kitchenette which also serves as dining room The hospital unit has twelve "sick bays," of which six with a total of twenty two beds are for women, and six, with twenty-four beds altogether, are for men There are also three isolation rooms The common rooms include a dining room, library, auditorium with stage and seating 250 persons, billiard room, and several small sitting rooms There are, of course, all the usual service departments Near the main building are six semidetached houses of 470 square feet each Three of these are for two person occupancy and include two rooms and kitchenette, the other three are intended for three people and have three rooms and kitchenette

In summary, it may be pointed out that the principles, although not universally applied, of housing which are being developed in Europe and the United Kingdom take cognizance of the personal rights of the individual to freedom of choice independency, privacy, and personal dignity Through the medium of suitable living accommodations, the older person is able to remain a functional part of the community and to find a receptive attitude toward himself The family is considered of major importance but is protected from being overburdened by the fact that older members have available to them accommodations outside the domain of the younger family Finally, architectural and social planning are providing facilities and trained personnel for the rehabilitation and maintenance of health, occupation of time in interesting activities, and the satisfaction of close personal relationships

F Programing and Design

The foregoing discussion of design has made some reference to space allotted in both independent housing developments and communal homes for recreation, crafts social activities, and health programs of various kinds The impression may have been created that European houses are designed to emphasize activities of the residents Such an impression would be incorrect, because while this need is not neglected altogether, actually only a minimum space is assigned for use in group activities beyond passive sitting

It is probable that this situation will not persist much longer because there is an increasing perception of the importance of what Mehr (1957) calls "leisure service for the aged," for old people living either in the community or in old age homes In chapter ix Havighurst discusses some of the new developments in this field

The very large old age homes do contain hobby and craft shops, auditoriums for

which house 400–500 essentially able bodied residents, the recommended ratio is 1 staff member to 7 or 8 residents In the small voluntary home, where there is likely to be considerable nursing required, the ratio is 1 to 5 (Rowntree, 1947) Shortages of staff are, however, grave, and an old persons' home recently constructed could not be opened for lack of personnel

The quality of staff is also considered in setting up standards because it is fully recognized that the happiness of the residents and the success of the homes are as dependent upon the personal characteristics of the matron and her assistants as upon their training

TRAINING PERSONNEL

During the last 10 or more years the rapid multiplication of the small old peoples homes accommodating from 30 to 40 persons has created a severe need for qualified persons to manage them This has led several countries, usually through voluntary agencies, to establish training courses for potential matrons and wardens

Two examples of these courses are included here because such training is needed in the United States and is not yet being undertaken on any systematic basis There are signs however, that it is only a matter of time until specific training will become a requirement by licensing agencies in this country European experience will offer [illegible]

longer and more comprehensive The British training course offers a useful pattern however because it illustrates a successful joint effort on the part of agencies in planning supporting, and offering the course The moving force in organizing the training program is the National Old People's Welfare Council In the past the program was assisted financially by the National Corporation for the Care of Old People, the Thomas Will Trust and the King George VI Foundation Today, additional grants for the training programs are available from the education authorities

The stated goal of the course is to develop "a cadre of enlightened people to help the elderly not only in old people's homes but in their own homes" The first course was offered in 1950 (Great Britain, National Old People's Welfare Council, 1954*b*) It is now offered to from 30 to 35 students each year The course is 14 weeks long and is entitled "A Training Course [illegible] and Assistant Matrons of Old [illegible] no [illegible] are [illegible] ose with some knowledge of nursing [illegible] nag ing other types of institutions are preferred (Great Britain, National Old People's Welfare Council, 1953*a*) Women between the ages of 27 and 50 are considered the most suitable trainees Tuition alone is £35 (about $98) The total cost to the student, including travel and living expenses is estimated at £120 (approximately $350)

The course consists of two parts theoretical training and practical work The first 3 weeks are spent in practical training in an old people's home (1 week each with the assistant matron, the cook, and the matron) Four weeks of theoretical training follow, supplemented by field trips for observation of various old people's welfare programs Four weeks are then spent in practical training in the geriatric unit of a hospital and the next 3 weeks in an old peoples home The course is completed with a final 2 days of discussion and evaluation of the experiences

The following is a syllabus of the lectures offered during the theoretical part of the course (Great Britain, National Old People's Welfare Council, 1953*b*)

Historical Introduction (2 lectures)
Position of older citizen in society, pension schemes, work of voluntary religious, and governmental agencies, dissolution of poor law and its replacement by new legislation, development of old age homes before the National Assistance Act

the skills of the staff When the goals are more than domiciliary or custodial—when there is concern for the social and psycho logical needs of residents as well as for their physical well-being—it may be con sidered that the home is under advanced management and that it is seeking to com ply with the best practices of the day

Generally speaking, most western Eu ropean countries are well advanced in their desire to assist in creating good lives for the old people and with reference to staff resident ratios, types of personnel required, and integration with other community ag- encies and resources In some cases the standards are made statutory, in others they are recommended practices In this connection, it may also be said that some of the European countries are giving world leadership in the provision of organized training programs for matrons and wardens of old age homes

PERSONNEL STANDARDS AND PRACTICES

The staff-resident ratio in housing proj ects consisting only of independent living quarters is usually quite small This rep resents a planned attempt to encourage old people to continue to meet their own needs, in part because the able bodied require much less service than the frail, disabled, or ill who are usually to be found in the institutions for the aged, and in part be- cause there is a desire to keep costs at the lowest levels consistent with good housing practices

In the housing estates in England, there is usually a housing manager who is re sponsible for management, rent collection, and liaison between the administration (lo cal authorities, housing trusts, etc) and the residents In recent years there has been a tendency to appoint a warden also to give some slight care when necessary to elderly people in flats or small houses on a housing estate There may also be as sistants to do yard and maintenance work In the Swedish pensioners' flats, which house from 200 to 250 persons, the staff is somewhat larger and includes a house mother, nurses (probably three), and a cook if there is a common dining room Re sponsibilities of the housemother are those of general administration, summoning a doctor in case of illness, arranging for ad mission to hospital or nursing care when necessary, and supervision of the staff The practical nurses help the pensioners with shopping, preparation of food, housekeep- ing and other chores when such assistance is required The staff of larger homes may include a social director All the projects of course, have the requisite number of custodians

The communal homes naturally have a larger professional staff because the resi dents require a larger measure of assistance with their daily activities of living and more frequent nursing care and rehabilita tion service In a Swedish home accommo dating about 40 people (the number rec ommended as an ideal size) the staff is made up of the matron who is usually a trained nurse and a graduate of the special training program for matrons of old age homes, a corps of five or six practical nurses, a cadre of household help, and a part time occupational therapist, physical therapist, and physician A social case- worker is not included, even in most of the larger homes, in the belief that, when such help is required the worker from the social welfare office can supply the service

The auspices under which a home is op erated are also often major factors in de- termining the type, number, and responsi bilities of staff members Those under the sponsorship of large organizations usually have fixed rules and specialized manage ment services, thus relieving the matron of business and managerial responsibilities In the small homes under local voluntary bod ies much of the business detail, such as rent collection and property management, is carried out by members of the voluntary organizations

The staff resident ratio is, of course, con sidered an important factor in the economic and humane administration of a home In England, in public assistance institutions

In the Netherlands the Committee on Training of the Dutch Federation for the Care of the Aged plans and prepares the programs for training of personnel to work in homes for the aged. Dr R J van Zonneveld chairman of the committee, reports that since 1955 a 2 year training program for intern home helps in residential homes has been in operation and that during this 3 year period 450 girls have passed their examinations Refresher courses for matrons of old age homes have also been organized by provincial social welfare bureaus Currently in the planning stage are programs to be sponsored by the Dutch Federation for the Care of the Aged for a 2 year training course for special nursing aids for the aged in nursing homes

TABLE 3*

TRAINING PROGRAM FOR MATRONS OF OLD AGE HOMES AND METHODS OF MEETING COSTS TO STUDENTS

Schedule of Courses	No of Months	Provided to Student†
Probation—old people s home	1	Board and room
Theory I	1½	Board and room
Practice—old people s home	7	Board room cash allowance
Practice and Theory—general hospital	12	Expenses reimbursed by state
Practice—mental hospital	3	Salary
Theory II	3	Defray own expense‡
Attendance—old people s home	4	Board and room
Theory III	3	Defray own expense‡

* Source Based on Hamrin (1957)

† The student provides own books and supplies

‡ Can apply to the general student loan fund for help

IV Community Services

When old people live near their relatives or with their children they usually receive many important personal services from them as well as the satisfactions of companionship and affectional relationships Yet as a part of the great complex of social and economic changes of the past decade the family structure in almost every developed country is moving toward the nuclear unit as opposed to the extended kinship of three generations and collateral relatives as in the past Coincidently, there is a diminishing expectancy of family responsibility for its older members Much social legislation, therefore, has been aimed at providing substitutes for the financial support and security formerly found in the extended family setting Old age pensions health insurance, special rent and clothing

ly of their families and outside an institution To a certain extent, these measures are accomplishing their purposes, but, to the degree that older people become frail and unable to care for their own personal needs, to perform the normal activities of daily living to find social contacts in the community around them—to that extent additional assistance must be provided if they are to remain free in their living arrangements and actions Thus for approximately the last 10 years most of the countries of western Europe and Great Britain have been developing systems of interrelated and co-ordinated services to prolong the period of usefulness, health, and independent living of old people

A Costs of Home Services versus Cost of Institutionalization

These programs have now been in operation long enough to permit some evaluation of the extent to which they are accom

Legislation (7 lectures)
National Insurance Act 1946, National Health Act 1946, National Assistance Act, 1948, conditions of service for staff at old people s homes

Social Background (6 lectures)
a) Old people in the community including discussion of effects of different types of housing old people s needs, description and evaluation of different types of old people's welfare services offered in their own homes, place of the home in the community, keeping residents in touch with activities of the district
b) The work of the National Old People s Welfare Committee

Household Administration (6 lectures)
a) Domestic administration—housekeeping cleaning heating use of different types of heat for cooking sanitation
b) Office organization—records admittance bookkeeping staff insurance taxes, work and vacation assignments license requirements menus wills death etc

Catering and Nutrition (9 lectures)
Kitchen equipment and layout buying and storing food principles of preserving and cooking food care and cleaning of equipment essentials of good nutrition menu planning food service

Elementary Psychology (4 lectures)
Understanding human behavior changing attitudes and prejudices improving interpersonal relationships emotional adjustments

Psychological Effects of Aging (3 lectures)
General approaches to old people the nervous system in old age general hints on handling old people

Home Nursing for the Elderly Sick (10 lectures)
Nursing the bedfast care of sickroom management of patients nursing procedures first aid prevention of accidents

Occupational Therapy and Leisure Time Activities
Kinds of activities and their use in rehabilitation of old people [pp 2 5]

In addition to the 14 week course, the National Old People's Welfare Council has also been offering a series of short "Refresher Courses" for the in service training of wardens and matrons from both voluntary and local authority homes These are similar to the short courses offered by a number of educational institutions in the United States for the in service training of nursing home administrators The course lasts 5 days Tuition is £7 10s (about $26) and this covers tuition, room, and food Topics covered by lectures include statutory provisions for the aged psychological effects of aging, problems of sickness modern methods of rehabilitation, household management, catering occupational therapy, and aids for the disabled Each training course is limited to 25 students Attendance at refresher courses varies from 35 to 45 persons

The Swedish Welfare Association has been training matrons since 1908 and is today the official training agency for Sweden The comprehensive training program requires 34½ months to complete Prerequisites for enrolment are (1) age—22-30 years (2) education—at least primary and preferably high school (3) training and experience—in housekeeping (4) skills—proficiency in sewing weaving cooking, (5) health—physician's certification of good health based on a physical examination and (6) insurance—member of an approved sick fund (Hamrin, 1957)

The course content includes both practical experience and theoretical studies The practical training is obtained in old age homes general hospitals, and mental institutions

Table 3 summarizes the schedule of training and method of meeting the costs to the student Tuition is free throughout the 3 years

The theory courses include lectures in the following fields anatomy physiology, public health nursing and techniques, psychology, social legislation Swedish language, mathematics methods of occupational therapy, psychiatry, nutrition and dietetics, civics, social legislation institutional management, and bookkeeping Field trips to old age homes and institutions are also a part of the training program

In the Netherlands the Committee on Training of the Dutch Federation for the Care of the Aged plans and prepares the programs for training of personnel to work in homes for the aged Dr R J van Zonneveld, chairman of the committee, reports that, since 1955, a 2 year training program for intern home helps in residential homes has been in operation and that during this 3 year period 450 girls have passed their examinations Refresher courses for matrons of old age homes have also been organized by provincial social welfare bureaus Currently in the planning stage are programs to be sponsored by the Dutch Federation for the Care of the Aged for a 2 year training course for special nursing aids for the aged in nursing homes

TABLE 3*

TRAINING PROGRAM FOR MATRONS OF OLD AGE HOMES AND METHODS OF MEETING COSTS TO STUDENTS

Schedule of Courses	No of Months	Provided to Student†
Probation—old people s home	1	Board and room
Theory I	1½	Board and room
Practice—old people s home	7	Board room cash allowance
Practice and Theory—general hospital	12	Expenses reimbursed by state
Practice—mental hospital	3	Salary
Theory II	3	Defray own expense‡
Attendance—old people s home	4	Board and room
Theory III	3	Defray own expense‡

* Source Based on Ham n (1957)
† The student provides own books and supplies
‡ Can apply to the general student loan fund for help

IV COMMUNITY SERVICES

When old people live near their relatives or with their children they usually receive many important personal services from them as well as the satisfactions of companionship and affectional relationships Yet as a part of the great complex of social and economic changes of the past decade the family structure in almost every developed country is moving toward the nuclear unit as opposed to the extended kinship of three generations and collateral relatives as in the past Coincidently, there is a diminishing expectancy of family responsibility for its older members Much social legislation, therefore, has been aimed at providing substitutes for the financial support and security formerly found in the extended family setting Old age pensions, health insurance, special rent and clothing allowances, etc., are aimed at making it possible for the elderly to live independently of their families and outside an institution To a certain extent, these measures are accomplishing their purposes, but, to the degree that older people become frail and unable to care for their own personal needs, to perform the normal activities of daily living, to find social contacts in the community around them—to that extent additional assistance must be provided if they are to remain free in their living arrangements and actions Thus for approximately the last 10 years most of the countries of western Europe and Great Britain have been developing systems of interrelated and co-ordinated services to prolong the period of usefulness, health, and independent living of old people

A Costs of Home Services versus Cost of Institutionalization

These programs have now been in operation long enough to permit some evaluation of the extent to which they are accom

plishing their purposes In general, there appears to be agreement that old people like and want the services and that these services are keeping many older people out of old age homes and from occupying hospital beds The question now of major concern is that of the accuracy of one of the premises on which the maintenance of the independence of old persons is based—that is, that it is more economical to provide home service for some of them than it is to maintain them in institutions

TABLE 4*

ANNUAL EXPENDITURE OF PUBLIC FUNDS FOR PENSIONERS LIVING IN VARIOUS TYPES OF ACCOMMODATIONS DENMARK 1950

Location	Expenditures per Person (In Kronor)†		
	State	Municipality	Total
Own home	1691	673	2364
Old home for the aged	2200	2120	4320
New home for the aged	2700	2600	5300

* Source Based on Friis (1956)

† There are 5 18 kronor to one United States dollar

Henning Friis (1956) has made a comparison of the relative public agency costs in Denmark per individual of maintaining an older person in old and new homes for the aged and in his own home The results are presented in Table 4 and indicate that in Denmark it is of major economic advantage to the community to find ways of maintaining old people in their own homes

As already pointed out, the Dutch find it more economical to give assistance to old people in their own homes than to provide institutional care for them until the time comes when daily nursing care is required In France the home care program for sick older people costs about 1000 francs per day as compared with 4000 francs per day for hospital care In Sweden it is estimated to be cheaper to provide 100 hours of domestic help per month for one person than to provide a place in an old age home

Shenfield (1957) has estimated the average costs of providing different types of services for old people and concluded that "it is worthwhile to spend up to 100 pounds [$280] per year to help keep an old person at home rather than in a home or hospital bed, and this can probably be achieved for a good deal less if family help is available" (p 170) The basis for her conclusion is presented in Table 5 As already mentioned, however, there is now some question whether the costs would differ greatly if other expenditures of old people living at home (which may be provided by National Assistance or partly subsidized pensions) were added to the costs met directly by public services

There appears, however, to be general agreement that under most circumstances it is economical to provide community services to help keep old people in their own homes The other hypothesis that old people are necessarily happier to remain independent has not been so well authenticated Thus Shenfield (1957) cautions that "where however old people live alone and have no help from relatives or neighbors the happiest arrangement for them is not simple to decide" (p 171) This is a matter which invites further study

TABLE 5*

ESTIMATED AVERAGE COST IN ENGLAND OF DIFFERENT LIVING ARRANGEMENTS FOR THE OLD

Living Arrangement	Cost per Year (In Pounds)
Chronic hospital bed	400
Local authority home	200
Halfway house	320–350
Voluntary body home	180 195
Flatlet or hostel	600
Boarding with private family	130–150
At home with domiciliary services†	80–100

* Source Based on Shenfeld (1957)

† Includes home-help laundry some hot meals, some nursing care attention of general practitioner and other general medical services

B Types of Community Services

There is a good deal of similarity among countries in the types of services provided

older people living at home In general, they include domestic aid, health care, meals, social contacts, and educational recreational experiences These services are often referred to as "open-care" as opposed to the care offered in old age homes or similar institutions

DOMESTIC AID

Household help is the most common form of service offered and is available to some extent in all the countries of western Europe England was the first country to initiate the service, but Sweden now has an equally extensive program. In January, 1958, legal provision was made in the Netherlands to provide special home help service to old people Under this new plan, which is subsidized by the Ministry of Social Welfare and local agencies, homehelpers may work on an hourly wage scale and thus offer short time or temporary assistance to old people or, on the other hand they may (for the first time) give service to the aged for an indefinite time when long term assistance is required.

TABLE 6*

OPEN CARE GIVEN DURING 1956
GOTHENBURG BY AGE

Age (in Years)	No of Persons
Under 50	46
50–59	1 7
60–69	538
70–79	1476
80–89	868
90-100	76
Total	3131

* Source *Redogörelse för den öppna ål dringsvården Göteborg a 1956* (Gothenburg, 1957) (Mimeographed)

Household help for old people is, in most countries an extension of the homemaker service developed originally to assist families in times of a mother s illness or absence from home This has generally meant that the amount of service available to old people has been very limited, since it has been difficult to secure enough household helpers to supply the needs of even the young families In order to improve this situation partially, a number of countries have developed separate systems of household help for the aged

The tasks generally performed by the domestic helpers include cleaning, cooking, light laundry, and shopping A twice-yearly housecleaning is also sometimes included

TABLE 7*

OLD PEOPLE DROPPED FROM OPEN CARE
GOTHENBURG 1955
(N=3131)

Reason Dropped	No Dropped
Died	53
Hospitalized	353
Entered old people's home	97
Relatives took over	112
Improvement in health	128
Other	17

* Source *Redögörel e för den öppa ald ingsvarden i Göteborg ar 1956* (Gothenburg 1957) (Mimeographed.)

In general, domestic aid is intended to offer assistance with the harder tasks of housekeeping, leaving the simpler day to day management of the household to the older person The household helper may come daily or a few times a week, and each visit is usually between an hour or two in length The helper is trained to report illness she may find to the district nurse or to the social welfare center, thus there is an extra measure of protection afforded

As would be expected, there is an increase with age in the number of persons receiving the domestic aid Table 6, based on the Gothenburg, Sweden, program, illustrates this point

For the most part, open care for the aged is a long term or permanent arrangement Table 7 indicates that only 4 per cent (128) of the 3131 persons in the case load improved to the point where the service was no longer needed

Another measure of the permanency of care needed is indicated in Table 8 The service in Gothenburg started in 1952, and 35 persons who initially were in the program were still receiving aid in 1956

It appears that if the open care is de

signed as an alternative to institutional care, it may be expected that a majority of cases will require continuing service. The more successful the program in aiding people to continue to maintain their own households, the greater the duration of their need unless relatives can be persuaded to take over.

The laundry work done by the household helper is usually confined to personal items. The heavy work of laundering household linen (sheets, etc.) is so difficult that a number of communities and voluntary groups have developed laundry services or use of rental bed linen service. In England, for example, the National Assistance Board

TABLE 8*

DURATION AND NUMBER RECEIVING OPEN CARE, GOTHENBURG 1956

Duration	No.
1 month	77
1–6 months	485
6–12 months	408
1–2 years	783
2–3 years	638
3–4 years	349
Over 4 years	35

* Source: *Redogörelse för den öppna åldringsvården i Göteborg år 1956* (Gothenburg, 1957). (Mimeographed.)

may give supplemental grants to old people to cover laundry costs. The importance of this service to the old people can be seen in the fact that, of 821,000 special grants made by the board, 314,000 were for laundry costs (Shenfield, 1957).

HEALTH SERVICES

As in the United States, there is a shortage of long stay hospital beds in practically all countries. In consequence, measures have been taken to conserve the available beds for the acutely ill and to supply care for the longer convalescent periods or for the chronically ill in the home. A brief summary of these plans is appropriate here since they constitute an important part of the community services for old people.

The most usual home health service offered is bedside care. This service is organized similarly to the visiting nurse program in the United States. The nurse goes into the home daily or as needed and gives bedside care, medical treatment, special medications, and baths and massage and makes the patient comfortable. She may also offer counsel and guidance in health matters to the patient and his family.

Other types of home health services are now being offered as a result of the growing emphasis on rehabilitation of older people and on preventive measures. In England, for example, physical and occupational therapists visit and treat the aged blind and disabled who are in need of training in activities of daily living and of restorative occupation. Occupational interests of other elderly persons are encouraged through competitions, instruction by local educational authorities or women's institutes, guilds, etc. (Great Britain, National Old People's Welfare Council, 1958a). A chiropody service has been established in many areas by local old people's welfare committees with the support of grants from the National Corporation for the Care of Old People or from the local authorities. As of April, 1959, the National Health Services Act of 1946 was amended to allow local authorities to grant aid to voluntary bodies to provide chiropody services. The premise is that, if old people are to stay on their feet, then their feet must be kept in good shape. Chiropody service is often available at the meetings of old age clubs as well as in the homes of old people.

In addition to the organized health programs such as the home nursing services, mobile physiotherapists and occupational therapists, mobile meals, etc., effort is made to provide remedial devices to those who need glasses, dentures, hearing aids, crutches, artificial limbs, etc.

FOOD SERVICES

Several types of food services have been developed to provide nourishing meals for impoverished old people and for those who live alone but are too frail or disabled, lack

the skill as in the case of many men, or neglect to cook properly for themselves

The meals-on wheels service, which began in England and has spread to a number of other countries, including the United States, brings hot well planned meals to the homes of selected old people The British Red Cross Society started the first scheme and, with other voluntary agencies such as the Women's Voluntary Services and some old people s welfare committees, now support and operate the program Candidates for this service are the bedbound who have no one to care for them the disabled living in high rise apartments without elevators, and those who are considered medically too frail to be able to care for their own nutritional needs

The meals are usually planned by a dietitian and are prepared in community kitchens, in industrial canteens, at the headquarters of voluntary groups and in the kitchens of private caterers They are transported in insulated containers by motor (van or private car) or in the Netherlands, by bicycle The food is transferred to the service plate or heating pans of the old person so that there is no actual interchange of crockery A sample English meal includes a piece of meat or steamed fish a boiled potato a vegetable and a steamed bread pudding The number of meals delivered to an old person per week varies according to the need and availability of the service but as a rule delivery is not made daily Enough food is often taken at one time to supply a second meal

Mobile meal services are found in addition to England in Sweden and Denmark where the residents of the pensioners' flats may choose this service in preference to cooking for themselves or in instances of temporary illness In Sweden about 8 per cent of the elderly living in their own homes receive the service

Another form of food service found in England is the dinner club which provides opportunity for a group of lonely old people to come together daily for at least one warm meal at a nominal cost These are separate from the community kitchens which were a wartime measure and are now largely abandoned, where any person, regardless of age, could get a meal at a very nominal fee Naturally, because of the cheapness of the meals, these kitchens had many old people among their clients

In France there are day centers for the elderly—*foyers*—where old people come about 11 00 A M or noon to have a warm lunch They spend the afternoon in card playing, reading, or other activities and then go home at 5 00 or 600 P M, taking a hot evening meal with them Some of these clubs are formed in connection with the community hospital. They are often housed in separate buildings but on the hospital grounds, according to M Renaudin, president of the Committee for the Organization of Aid to Old People (a federation of 14 000 private organizations in France) A private association, Amis des Vieux, coordinates private ventures for providing poor old people with meals Another, the Brave Gens, helps old people by distributing food parcels (French Committee for Social Service and Social Work, 1954) The municipal Social Service Bureau, which is administered by committees of which two-thirds of the members are nominated from among people doing social work in the commune, runs communal restaurants for old people

Large cities in the Netherlands, such as Rotterdam and Amsterdam, and some smaller communities have a meals on wheels service for old people The Municipal Welfare Department buys the food and has it prepared in municipal kitchens. The Women s Voluntary Service distributes the meals four times a week to the old people

SOCIAL ACTIVITIES

Acute loneliness is found among old people in every country There are always some who have little or no family left and whose social resources are practically non existent In addition, many are too handicapped physically or too mentally de-

pressed and discouraged to be able to find a solution to their own loneliness Yet they desire independence and a role in life An almost universal problem of old people is the fear and dislike of continual dependency upon family, especially if this means taking refuge in the homes of their children, where they crowd the young family for space and interfere with its freedom of action In chapter ix Havighurst has dealt at length with the attempts being made in various countries to provide roles for older people in which they may find satisfaction and secure ego support The following is a brief overview of these developments as a part of the community services being made available to the aged

The services designed to provide social relationships for the elderly include in most countries such activities as friendly visiting, old people's clubs, vacations, and short in residence hospital visits to provide relief for young families and a change for the aged

The friendly visiting program is essentially of the same nature as in the United States Usually members of a volunteer organization or church group visit old people in their own homes and perform such services as writing letters, reading aloud lending a listening ear, doing such chores as shopping, making telephone calls, etc Old people do not pay for this service

In the Netherlands the Union of Women's Volunteers has a visiting program and operates 250 old people's clubs In Amsterdam about 40 per cent belong to the League for the Aged The league according to De Haan (private communication, 1957) provides both cultural and recreational activities for its members through a system of social clubs In England the Women's Voluntary Service and the many voluntary Old People's Welfare Council Committees have extensive visiting programs These visitors are instructed to call *regularly* upon their [illegible]

ters, [illegible] fering friendliness They are also urged to judge whether there is a need for services from other sources such as meals on wheels, home helps, gift food, blankets and bedding, and medical equipment (bed rests, etc) The visitors may also serve old people living in hostels and old age homes

Other types of programs which are offered in some countries to call the attention of citizens to the needs of old people at the same time offer a measure of socialization for them In Copenhagen there is an annual "Old People's Week" sponsored by the Lutheran parishes During this week younger families are encouraged to invite one or more older people to their homes. Out of these visits, permanent relationships are sometimes established In France the National Committee for Organization of Aid to Old People sponsors an annual "Old People's Day," which is always the last Sunday in October In addition to the collecting of money which is used to support services for the aged in France, the organization promotes a program of visiting The social workers of various agencies supply the names of old people who are poor The names are put in sealed envelopes which are distributed in public places together with an invitation urging that the old person be visited on "Old People's Day" The National Committee reports that many friendships have been formed which endure throughout the year and bring great happiness and benefit to the old

EDUCATIONAL AND WORK ACTIVITIES

For the most part European countries have probably given less attention to the provision of educational activities directed to the elderly than has the United States The folk schools of Denmark, Switzerland and Sweden have older people among their clientele

Increased attention is being given to the establishment of work programs for the aged The Finnsbury Scheme for the Employment of the Elderly, in London, is an example It was started by Dr Blythe

Brooke a public health officer to serve the needs of patients appearing daily at the clinic requesting medical service but with no apparent illness beyond loneliness Dr Brooke rented an old house and advertised that work would be available for elderly people Many of the old people who had gone to the clinic transferred to the workshop where they worked at simple sewing packaging or assembly tasks for 2 hours a day Their remuneration was 1s an hour (14 cents) So successful was this experiment that a new building was constructed offering more space and equipment The National Old Peoples Welfare Council (1958b) has recently reported on several other workshops and employment schemes for older people and lists the sources of grants in a d for these programs

In France the National Committee To Aid Old People in 1950 created a home work program for old people who were unable to work normally after retirement age Under this plan highly skilled workers make quantities of such items as children's clothes dolls etc. Some of the large stores in Paris and other cities have given space and a sales stand to the committee for the display and sale of these items The old person receives 70 per cent of the profit the store receives 10 per cent and the com m ttee gets 20 per cent in order to make it possible to continue the work

OTHER FORMS OF CARE SERVICES

Night attendance services provide persons to s t with old people who cannot be left alone during the night or to relieve relatives so that they can get enough rest to carry on the nursing of an elderly patient at home

Foster home care is another new service in which older people are placed as permanent paying guests in a private family It is expected that this type of care will relieve demands for communal care and also it is thought that foster home care may be more economical than institutional care (Bucke 1956)

Day centers and day clubs have been developed where meals and other personal services such as bathing are provided Most important are occupation and the opportunity to enjoy the company of others These centers are considered valuable preventive community care for old people who might otherwise have to enter a home or hospital

Housing management is a service which provides a manager who assists the aged person solve the practical problems of giving up old homes and settling in new ones This service is said to increase the sense of security of older tenants and to relieve needless anxiety

C Eligibility Criteria for Community Service

Not all old people are presumed to require special home services and there is great variation in the amounts and kinds needed by those who do require them For this reason costs are not included in the basic pension but are provided as a supplement when ne d d

comes necessary to establish rules of eligibility

Various criteria are used Generally, it may be said that the person must be of pensionable age unless special circumstances obtain of low income and usually in poor health although not necessarily sick The usual but not universal policy is to provide the services rather than to urge reluctant families to assume responsibility for giving them

In Gothenburg Sweden only such persons receive services as are eligible to a room in an old people s home or a bed in a hospital (Nordstrom, 1955) The services in England are made available upon the recommendations of physicians social workers d strict nurses welfare officers clergymen etc. In the Netherlands eligibility is more strict, to receive help the old person must have a medical indication of need cer

tified by a physician In Hamburg Germany, the program of home care is under the supervision of doctors, who often request the services through district welfare and health officers

D Sponsorship and Financing of Community Services

Community services are sponsored and financed in a variety of ways Usually some government subsidization is available, and local authorities may use such funds to establish and operate programs themselves, or the local authorities may use the state subsidies and add local funds to arrange for voluntary groups to organize and manage the program In addition national and local voluntary agencies and foundations may underwrite the services and provide the personnel or they may make grants to local committees on aging to set up the programs The Red Cross in Sweden the Foundation for the Aged (Pro Senectute) in Switzerland, the Women s Voluntary Services in England the Union of Women Volunteers in the Netherlands and the National Committee To Aid Old People in France are all illustrations of voluntary groups sponsoring and usually financing at least in part one or more types of community services for the aged

In the Netherlands as already noted the Ministry of Social Welfare may make subsidies to organizations of churches and/or private agencies which have as their objective the provision of homemaker service or household help In such instances the federal government contributes 25 per cent of costs the municipality 25 per cent and the voluntary group 50 per cent plus the work

There are two publicly supported home helps in Sweden one subsidized by the state offers assistance to families and to some old people, the other a special home help service for the aged supported by municipal funds serves only old people In 1955, all but 5 of the 1031 municipalities in Sweden had a state subsidized home-help program, while 441 of them also had a municipally supported scheme Of the latter, 315 were under management of local public authorities, while 126 were being administered by private associations (Nordstrom, 1955) The Swedish Red Cross also sponsors and finances a national home-help service

In England local authorities are responsible for providing a home help service This scheme originating during World War II, was made permanent under National Health Service and included old people as well as the sick and the mothers of young children The local authority employs and pays the home helpers In some areas the Women's Volunteer Services administer the program for the local authorities

In France financial support for the home care program is provided by the National Committee To Aid Old People whose funds come in turn from collections made on the annual 'Old People s Day" ($350 000 was collected in 1953 for example) Relief societies in the various communities which usually have nurses and homeworkers already on the staff supply the personnel

Another source of subsidization of the home service programs is the fees paid by the older people The rates paid are so small however as to be almost negligible in the total cost of underwriting a program

In England the local authorities try to recover all or part of the cost from the household of the old family if the family has resources Charges to the old person are based on a sliding scale In 1948 for example the service was free to those whose income was 26*s* ($3 64) or less a week but when the income was as much as 38*s* ($5 32) a charge of 2½*d* (about 3 cents) per hour was made

The Gothenburg fee rate in 1956 ranged from free service to 3 kronor (about 60 cents) per hour as shown in Table 9 These figures make clear that about 80 per cent of the service is given without cost to the recipient The total cost of the open care program in Gothenburg is reported as

2 930,365 kronor ($569,459) for 1957 Fees collected from the old age group amounted to only 165,000 kronor, municipal grants make up the remainder of the sum

E. Amount of Community Services Provided

How well the community services succeed in meeting the needs of older people is, of course, dependent upon the number of persons reached and the quality and quantity of assistance provided each of them.

Monsieur Renaudin, president of the [illegible] Old [illegible] ports [illegible] ties) [illegible] rance during 1955, that is, about [illegible] nt of the older population Both domestic help and nursing service were provided in a ratio of 3 hours of home help to 1 hour of nursing service

In Stockholm, during 1954, state aided home help was given regularly to 4389 old persons and occasionally in 18 823 cases This amounted to just over 1 000 000 hours of help to old people (this excludes the old people who were members of families receiving family home help and who were thus indirectly aided) Municipal home-help services reached also several hundred more persons (Nordström, 1955) In Stockholm the municipal program provided 77,500 hours of domestic aid during a year (1953) and at the same time the Red Cross offered another 32 500 hours together the two programs served 1300 old people (Mehr, 1954) Gothenburg, another large municipality (365 000 population) did not initiate its home-help service for older people until 1952, but, by 1957 it was employing 1000 home helpers who were serving 2000 old people (Gothenburg Municipal Executive Board, 1957)

F Personnel for Community Service

As in any personal service, stress is placed on the quality and training of personnel employed to assist and care for old [illegible] reliability, atti- [illegible] an un- [illegible] rded as important Assuming that this type of personnel can be recruited, questions of training, supervision of workers, standard of performance, and rate of pay then become major concerns of organizations administering the various programs Margareta Nordström (1955), an enthusiastic supporter of home help service, sounds the following warning

TABLE 9*

FEE RATE PAID BY OLD PEOPLE FOR HOME HELP, GOTHENBURG, 1956

Rate per Hour (in Kronor)	No Paying
Nothing (free)	2249
50	214
1 00	110
1 50	51
2 00	54
2 25	5
2 50	46
3 00	46
Total	2775

* Source *Redogörelse för den årlige ålderdomsvården Göteborg år 1956* (Gothenburg, 1957) (Mimeographed)

> The home help principle is right but it has its pitfalls We need only to consider how much harm that can be done to the good purpose by dishonest or unfit helpers, more or less consciously wasted working hours or the tendency to throw on the shoulders of the public such responsibility that has from time immemorial been the selfevident duty of relatives and neighbours

RECRUITMENT

With these criteria for good home helpers, recruitment of workers is usually among middle aged women whose children have left home and who find they can now spend 2 or 3 hours a day assisting old people The part time nature of the jobs is conducive to employing these women with limited time There is, also, a feeling in many countries that, because of labor short

ages, women with full time available should be employed in full time jobs and not in home help services The age distribution of the home helpers in Gothenburg (Table 10) illustrates the tendency for middle aged women to enter this service

The methods of recruitment used are the usual newspaper advertisements and circulars Public meetings also are held to give information and to attract prospective home-helpers In one Swedish community a meeting was held for members of women's organizations and the association of old age pensioners The Swedish film *We and the Aged* was followed by a discussion of the care of the aged in their homes and the home help service A call for home helpers was made, and 30 women volunteered for service In another community a questionnaire was prepared and sent to 100 women Thirty responded to the questionnaire and half of them applied to become home helpers

TABLE 10*

AGE DISTRIBUTION OF HOME HELPERS GOTHENBURG 1956

Age (in Years)	No
20–24	67
30–39	397
40–49	647
50–59	522
60–69	162
70–72	5
Total	1800

* Source *Redogörelse för den öppna old negra deni Göteborg år 1956* (Gothenburg 1957) (Mimeographed)

All countries report that it is difficult to get women for housework In Hamburg Germany, it has been found that only a middle aged woman who wants part time work will seek employment as a home helper But, if they work as much as one-half time, they qualify for retirement pensions, according to W Flmer, director of welfare service (personal interview 1957)

TRAINING

Household assistant is a position in Europe for which young women are prepared through a standardized training course. Such household assistance is defined by the Dutch as the assistance rendered by skilled specially trained women employed by and working under the supervision of an organization in families where they substitute for assist, and instruct the housewife who as a result of sickness, insufficient preparation physical defects, or social conduct is unable to accomplish her household tasks suitably This assistance is meant to support or reconstruct a healthy family More recently, the "household assistant to the aged" has become more or less a specialized field of household assistance

The *training for household* assistant to the aged requires an additional year of training beyond the year required for the regular household assistant The regular curriculum includes courses on religious thought, family government, education and recreation, and such home economics courses as cooking and dietetics, sewing and mending and theory of laundry housework, budgeting, child care and nursing The additional year of specialized study in preparation for working with the elderly includes four major programs (1) general orientation in the old age problem including demography, health status and programs psychological and several other aspects of aging, and social legislation, (2) practical problems of living and working with the aged, (3) hygiene and nursing for the healthy aged person and (4) handicrafts and recreational activities

The minimum age requirement for admission to these training courses is 19 years and most applicants are young women Middle aged Dutch women who work prefer factory and office work Those who are married would lose status if they engaged in work outside their own homes

In Sweden household helpers for service to families are required to have from 3 to 15 months of training, the exact amount

depending upon previous experience Training for household helpers to the elderly, however, is not yet extensive in Sweden This may be the result, in part, of the fact that Swedish women, unlike Dutch women, go into household help service after their children leave home and are therefore already experienced housekeepers A few [illegible]

[illegible] hours of special training The program is sponsored by the Public Assistance Committee working in collaboration with the trade schools and is supported by funds provided by the municipality The course covers such topics as diet cooking housekeeping home sick care, psychological and sociological problems of old people, and ethical considerations In Shovda another Swedish town, there is a regular training course but the home helpers are called together occasionally for a social evening and a lecture on the care of old people "Information Day" is the method used by the village of Vreta Kloster to educate the home helpers Lectures are given by a physician a social welfare worker and a district nurse to inform the home-helper of available services

The Swedish Red Cross which has organized a home-help service also provides courses for persons who are to work with the aged The course consists of 42 lessons and includes lectures, demonstrations and practical work Topics covered are psychology of the aged needs for proper nursing care and exercise to avoid disablement, use of occupational therapy mental health and organization and administration of programs of home care

SUPERVISION AND SALARIES

The organization employing the service personnel and directing the community service programs provides the supervision of the workers It also fixes salaries and pays the workers directly The fees paid by the old people are turned in to the agency

In the Netherlands the Ministry of Social Welfare (1954) has issued a detailed directive regarding the subsidization of home help services and payment of the workers To be eligible for a government subsidy, an organization must have a supervisor of home helpers who is a person with at least 3 years of experience supervising homemakers and home helpers and holds at least a 2 year certificate in social work. Salary rates for home-helpers increase annually, beginning with *1150* guilders ($303) the first year *to 1750* guilders ($460) after 6 years of service

TABLE 11*

NUMBER AND ANNUAL EARNINGS OF HOME HELPERS, GOTHENBURG, 1955

Annual Earnings (in Kronor)	No of Home-helpers
5000–5500	5
4000–4999	14
3000–3999	56
2000–2999	162
1000–1999	465
500– 999	370
100– 499	345
Under 100	433
Total	1850

* Source *Redogörelse för den öppna ålderingsvården Göteborg år 1956* (Gothenburg 1957) (Mimeographed)

Home-helpers in Sweden are carefully supervised by trained professional workers In the case of Gothenburg where there are 1000 [illegible]

[illegible] applications for help, make investigations to determine need of persons making application, select and assign the home-helper, and then to supervise the work of the helper closely through home visits and records The housekeepers are paid by the Social Welfare Board, the rate is 3 kronor per hour, and the working time on an average is 1 hour and 40 minutes per case a day Transportation is paid by the Social Welfare Board. The amount earned annually by the home-helpers in Gothenburg is shown in Table 11

In conclusion, the recognition of the middle-aged woman as a person whose natural experiences as a mother and housewife especially fit her to undertake the role of home-helper is serving a dual purpose—the older people receive badly needed services, and the middle-aged woman finds a new and meaningful role when her duties as a parent are finished Thus there is in the process of being established a new societal pattern along lines in which many more social inventions must take place if the social health of the nations is to be best served

REFERENCES

BERGGREN, A 1958*a* Introduction to an exhibition of photo material about Swedish old age homes Stockholm Royal Social Board (Mimeographed)

——— 1958*b* *A short review of the principles* and programs for the care of the old aged Stockholm Royal Social Board

BOUWCENTRUM 1955 Huisvesting van Bejaarden Verpleegtehuizen Rotterdam Bouwcentrum (English text)

——— 1958 Huisvesting van Bejaarden *Verpleegtehuizen voor Geestelijk Bejaarden* ("Nursing homes for mentally infirm old people") AS 0 Rotterdam Bouwcentrum (English text)

BUCKE, MARJORIE 1956 Foster care for the elderly Social Service Quart , 30, 19–22

DAHLSTROM, HELGE 1956 Some notes on the old age care in Stockholm Stockholm Office of Social Welfare (Mimeographed)

DANISH MINISTRY OF LABOUR AND SOCIAL AFFAIRS 1953 Old age pensioners flats report of a survey Copenhagen Danish Ministry of Labour and Social Affairs (Mimeographed)

DANISH SOCIETY 1951 Capital of a democracy Copenhagen Danske Selskat

DONAHUE, WILMA 1960 European experience in operation and services of retirement communities *In* E BURGESS (ed), Housing for older people the retirement community Ann Arbor University of Michigan, Division of Gerontology (In press)

ERLANDSSON, S 1954 Untitled paper Stockholm (Mimeographed)

FRENCH COMMITTEE FOR SOCIAL SERVICE AND SOCIAL WORK 1954 French report *In* Seventh International Conference of Social Work. Toronto

FRIEDEBURG, L VON 1955 Altersbild und Altersvorsorge der Arbeiter und Angestellten Frankfurt Forschungsbericht, Inst. fur Sozialforschung, Universitat.

FRIIS, H 1956 Calculations of possible savings *through the introduction of assistance in the* home instead of institutional maintenance of the aged in Denmark *In* The need for cross-national surveys of old age, pp 59–61 Ann Arbor University of Michigan, Division of Gerontology

GERMAN FEDERAL REPUBLIC 1958 Village experiment Bulletin, 6 (July 8), 8 Bonn Press and Information Office

GOLDBERG, L H 1959 Care of the elderly in Norway, Sweden, and Denmark observations from a geriatric study tour II Geriatrics, 14, 115–21

GOTHENBURG MUNICIPAL EXECUTIVE BOARD 1957 Social welfare policy in Gothenburg Handelstidningen Information Center of the Gothenburg Municipal Executive Board

GREAT BRITAIN MINISTRY OF HEALTH 1949 Housing Manual, 1949 London H M Stationery Office

——— 1950 Care of the aged suffering from mental infirmity London National Health Service (Mimeographed)

——— *1951 Housing manual supplement* 1951 London H M Stationery Office

GREAT BRITAIN MINISTRY OF LOCAL GOVERNMENT AND PLANNING 1951 Housing for special purposes London H M Stationery Office

GREAT BRITAIN NATIONAL OLD PEOPLE'S WELFARE COUNCIL 1953*a* Fourth training course for matrons and assistant matrons of old people's homes London National Council of *Social Service (Mimeographed)*

——— 1953*b* Syllabus fourth training course for wardens of old people's homes London National Council of Social Service (Mimeographed)

——— 1954*a* Age is opportunity London National Council of Social Service

——— 1954*b* Training and refresher courses *In* Progress report for the year ending 31st March 1954, pp 3–5 London National Council of Social Service

——— 1956 Memorandum on housing for elderly people London National Council of Social Service (Mimeographed)

——— 1958*a* Handicrafts for older people London National Council of Social Service.

—— 1958b Workshops and employment for the elderly London National Council of Social Service (Mimeographed)

HAMRIN GRETA. 1957 Utbildning av föreståndarinnor för ålderdomshem Stockholm Svenska Socialvårdsforbundet

HJEM HELEN M 1951 De Gamles By Copenhagen De Gamles By

KØBENHAVNS KOMMUNES SOCIALDIREKTORAT 1948 Københavns Kommunes Boliger for Aldersrentemodtagere Copenhagen Udgivet af Københavns Kommunes Socialdirektorat

M[illegible]

—— [illegible] The housing needs of elderly people Stockholm Office of the Mayor for Social Affairs (Mimeographed)

MOSS J 1957 Housing the elderly Health Horizon Summer pp 30–37

NETHERLANDS THE. MINISTRY OF SOCIAL WORK. 1954 Scheme of regulations for subsidizing of homemakers and home help services of 1955 The Hague Department of Family Serv[illegible]

[illegible] old age pp 53–58 Ann Arbor University of Michigan Division of Gerontology

ROGGENDORF DR 1951 Die Geschlossene Altersfursorge der Stadt Koln Cologne Reihler Heimstatten (Mimeographed)

ROWNTREE B S 1947 Old people London Oxford University Press (for the Nuffield Foundation)

RUDD T 1956 Caring for the elderly London Catholic Truth Society

SHELDON J H 1948 The social medicine of old age London Nuffield Foundation

SHENFIELD BARBARA E 1957 Social policies for old age a review of social provision for old age in Great Britain London Routledge & Kegan Paul

SWEDISH INSTITUTE 1956 Social benefits in Sweden Stockholm The Institute

SWEDISH SOCIAL WELFARE BOARD 1952 Social Sweden Stockholm Gernandts Boktryckeri

TEGNER G 1956 Social security in Sweden Tilden Swedish Institute

TOWNSEND P 1956 Family relationships *In* The need for cross-national surveys of old age pp 32–40 Ann Arbor University of Michigan Division of Gerontology

—— 1957 The family life of old people an inquiry in East London. London Routledge & Kegan Paul.

ULRIKSSON V 1958 Care of the aged in Sweden. (CRRP 1957 Sec. D Item VI A 5 Embdesp 763) Stockholm The Embassy

VI

The Health of the Aging[1]

VERA J. AND JEROME S. PETERSON

I. Physical Health

A. Biology of Aging

Aging is regarded by the biologist as a process that begins with life of the individual cells of which the body is composed, as a process of evolution and growth, involution and atrophy. The process of aging begins at birth and is most rapid in infancy, becoming progressively slower in childhood and maturity, and affects different tissues at different rates. Involution of tissue alters anatomical structures, physiological processes, and quality of functions, in particular those of adaptability. Biological age of the various organs is not uniform and may be even more variable with advancing years and in different individuals. The graying head is not necessarily a badge of old age, nor is the smooth skin a prerogative of youth. The thymus declines in function as reproductive organs spurt into activity. Degenerative changes in articular cartilages may occur in the second decade of life, and homeostatic mechanisms which maintain a constant internal environment may become less able to withstand stress as age advances. Within a broad pattern such variations occur depending partly on genetic and partly on exogenous factors, and at any given age a particular individual represents the sum of his inheritance and environment, his traumatic and infectious experiences.

For administrative and actuarial purposes the age of 65 for men and 60 for women has been generally accepted for retirement purposes in most countries, but chronological age does not define the "old" person; and today many men and women of these ages, or even older, can in no way be considered old.

Knowledge of the normal aging process is of fundamental importance in the medical treatment and palliation of the consequences of aging. Healthy old age is a normal process of involution accompanied by a satisfactory compensation to alteration in tissue structure and function. Health in the aged is not "rejuvenation" but the maintenance of physical and psychological equilibrium with the environment. Flanders Dunbar's (1955) study of aging and illness among centenarians in the United States portrays a special group of individuals who have managed to avoid the large majority of hazards which produce illness and invalidity and to retain the capacity to enjoy life and productivity. Two centenarians in Switzerland who had lived healthy active lives, free of any disability and escaping serious illness up to the end, were re-

[1] The authors wish to acknowledge the help of the following persons who read this chapter and made valuable suggestions for revision: Professor G. A. Canaperia, Alto Commissariato, per l'Igiene e la Sanita, Rome, Italy; Dr. Maria F Daelen, chief, International Health Section, Ministry of Interior, Bonn, Germany; Dr. Arthur Engel, director-general, Royal Medical Board, [illegible] lands.

ported to have a multiplicity of pathological organic findings at autopsy by Vischer and Roulet (1952) The orientation of the medical profession and other disciplines to the physiological and pathological changes that come with advancing years will provide a better understanding for assessing and meeting the personal, social, and medical requirements of old age

B The "Normality" of Old People

If health in the aged is the maintenance of equilibrium with the environment, what is the normal that has to be maintained? Assessment of normal from an insurance point of view is not applicable to old people Medical surveys carried out among the elderly repeatedly show that individuals who assess themselves as normal' are frequently found after medical examination to be suffering from one or more pathological processes. The criterion of 'normality' becomes the average for that age and the greater the age the greater the uncertainty of what constitutes the range of "normal variability from the standard for the young adult and as Sheldon (1948) puts it the more likely that the individual by sheer virtue of reaching that age must inevitably be normal The standard there fore for what is normal in old age Sheldon bases on elastic common sense,' and the distinction among aged aged and infirm and aged with chronic illness is often slight and unstable Medical surveys on various samples of aged populations have furnished useful information on the level of health of old people More surveys of this kind as well [illegible] ... of [illegible] take place from maturity to senescence and of what constitutes the 'normality" of old people

CALORIC REQUIREMENT AND NUTRITIONAL NEEDS OF OLD PEOPLE

Total caloric requirement is less in the aged than in younger people because, in general, there is a decrease in muscular at [illegible]

60 years of age Sinclair (1956) has summarized the caloric requirements for the average sized person age 60 years and over as 2000 calories for men and 1750 calories for women who are sedentary, 2500 calories for men and 2000 calories for women doing light work, and 2750 calories for men and 2250 calories for women doing medium work. Observations made on the food consumption of elderly people in surveys show that old people do tend to eat less and have a lower caloric intake than active adults (Food and Agriculture Organization, 1950) Hobson and Pemberton (1955) in a survey of old people in Sheffield found that the diet they consumed supplied a daily caloric intake of 2205 calories for men and 1826 calories for women These old people had been assessed as physically fit, and, assuming that physical fitness is related to diet, this caloric intake is adequate to meet the needs of aging individuals except where old people are working or physically very active, when caloric intake would need to be increased. A survey carried out near Sunderland, a coal mining and ship-repairing area in England of 1000 pensioners whose ages ranged from 62 to 97 years revealed that their caloric intake met about normal requirements on the diets they were eating, although protein intake was below the normal requirement in 37 per cent of the cases (Smith, 1957)

No marked change in diet is necessary in the absence of systemic disease or local lesions of the gastrointestinal tract. Protein and carbohydrate intake must be sufficient to maintain a state of positive nitrogen balance Proteins are important in maintaining serum proteins and resistance to infections Sinclair (1956) gives the daily requirements of protein as 72 grams for men and 60 grams for women Schulze (1955) advocates 1 0–1 5 grams per kilogram body weight of protein to enlarge the

range of safety for maintaining the body tissue in everyday life Intake of vitamins and minerals must be adequate to meet the increased need of aging tissue for these substances Calcium and iron must be sufficient to maintain normal metabolism and prevent anemia and demineralization of bone (Stieglitz 1950) Absorption of fat may be selectively impaired to a moderate degree It is considered better nutrition for the aged as well as the adult to reduce fat intake and to depend to a greater extent on proteins for their energy requirement However worthy of mention here in view of the recent literature on the relation of cholesterolemia to atherosclerosis is Sheldon's finding on the consumption of fat and a reversal in the role of Jack Spratt and his wife in the Wolverhampton survey While 21 per cent of the female sample could not eat fat, complaining of biliousness, 30 per cent of the male sample liked and even craved fats especially meat fat (Sheldon 1948)

Animal studies suggest that reduction in calories from birth might be an important factor in preventing physiologic aging Sinclair (1955) and others have shown that the evidence derived from animal experiments suggests that overfeeding in childhood causes early maturation and shortens life and that overfeeding after maturity increases the incidence of certain degenerative diseases that are common in old age Stare (1956) cites experiments from Guatemala Nigeria and North America to show that muscular exercise has a favorable effect on regulating serum lipids and serum cholesterol On high caloric intake no essential gain in weight or in levels of serum cholesterol or lipoprotein occurs if the excess energy is dissipated by exercise Stare concludes that high caloric diets are better utilized in early adulthood when energy turnover is high and that the same dietary habits in later adult life usually associated with a long period of diminished activity and decreasing energy expenditure result in an obese middle aged individual with poor muscle tone, high serum cholesterol and B lipoproteins and often significant atherosclerosis This is the individual who in the period of advancing physiologic age after middle age shows evidence of obesity and atherosclerosis with its complications The understanding and application of the principles of good nutrition are important in maintaining health and preventing disease with advancing age and research in nutrition, especially as it relates to the prevention of degenerative diseases of heart and arteries is one of the fruitful fields of gerontological research

Although insurance statistics show that overweight is an adverse factor in attaining longevity, many obese persons survive to old age In Sheldon s (1948) survey of old people living at home 449 of 463 subjects had a normal level of nutrition 3 per cent were undernourished and 25 per cent of the women over 85 years of age were obese In a clinical study of 450 apparently healthy patients over 54 years of age attending a consultative health center for old people in Rutherglen Scotland (Anderson 1955) more than 50 per cent were over ideal weight in the survey of 1000 pensioners in Sunderland over 75 per cent of the women were overweight (Smith 1957) Exton Smith (1955) states that a substantial proportion of subjects over 60 years of age especially women are overweight Obesity may not be a bar to long life but it is a liability in attaining longevity and in advancing years carries a high morbidity and mortality rate Conditions detrimental to health accompany obesity Hypertension is five or six times as common in the overweight as in the undernourished female Diabetes is a frequent concurrent of overweight and though mild in the aged carries the threat of circulatory complications Other conditions such as infections of the skin painful feet degenerative rheumatic affections of the joints causing pain especially in the weight bearing joints and dyspnea not due to respiratory or cardiovascular disease may be aggravated by obesity and result in disabling ill health in the elderly

The small but significant proportion of malnutrition found among old people was

due to restriction in activity which makes shopping and cooking difficult as well as to economic factors, apathy, and ignorance (Sheldon 1948, Hutchinson, 1954, Hobson and Pemberton, 1955) As the elderly reduce the bulk of food eaten it is necessary to see that adequate amounts of the essential foods are taken

METABOLISM

Homeostatic mechanisms that regulate and keep the different body systems in a steady state become less efficient with advancing age and the elderly adapt less readily to stress and changes in internal and external environment (Stieglitz 1950) Body metabolism is usually lower in persons over 60 years of age because of a decreased energy requirement of body tissue consequent to a decrease in muscular activity Observations by various workers reveal a significant reduction in basal oxygen consumption with increasing age The experimental work of Shock and his associates (1955) has demonstrated that under resting conditions the oxygen consumption of functioning cells does not change significantly with age A large proportion of the reduction in total basal oxygen uptake in older individuals may be attributed to the gradual loss of cellular elements which occurs with aging Studies of oxygen uptake (Shock *et al* 1955) of different organ tissues however indicate that certain tissues may show alteration in metabolic rate with age which may not be entirely explained by loss of functioning cells Much more research is needed to determine the part played by alteration in anatomical structure physiological processes and quality of functions and adaptability of aging tissues in modifying body functions

BODY TEMPERATURE

Old people complain of cold more than younger ones The mechanisms for preventing heat loss are less efficient in the older than in the younger person According to Cannon (1939) the decreased ability to withstand cold in old age apparently may be due to decreased heat production Thewlis (1954) states that in old age temperature may be below normal, Howell (1950), however, measured the temperatures of 326 healthy Chelsea male pensioners between the ages of 65 and 91 years, all ambulatory, apparently well, and not needing medical treatment, and found oral temperatures of 95 2° F–100 2° F and concludes that the range of normal temperature among the aged is greater than in earlier life Bastai and Dogliotti (1938) advise taking rectal temperatures, since in the old a marked difference is found between external and internal temperatures It is important clinically to recognize that infectious processes may appear with normal or even low, temperatures and that in some old persons a temperature of 98 4° F may be equivalent to 2°–3° of fever Temperature and pulse in the early stages of bronchopneumonia may be within the normal range and cause a delay in making diagnosis and instituting specific treatment

PULSE

Pulse rate of 335 healthy Chelsea pensioners was observed by Howell (1950), who recorded frequencies between 44 and 108 beats per minute The mean pulse rate fell between ages 60 and 84 years but rose sharply again after this latter age Variation in pulse rate in the old makes a pulse chart unreliable in trying to assess the onset of acute infections Pulse rate may have no bearing on severity of an infectious process or on the ultimate prognosis of the disease In a particular old person a pulse rate of 75 may be tachycardia

HEMOGLOBIN LEVELS IN OLD AGE

Some degree of anemia is the usual finding among the elderly Sheldon s (1948) inquiry into the nutritional status of 463 old people living at home revealed the presence of iron deficiency in 5 per cent of the women subjects, but no hemoglobin determinations had been done Hobson and Blackburn (1953), in a random sample

of old people, found hemoglobin levels below normal in 5 1 per cent of the males and 6 5 per cent of the females, women having lower values than men In both sexes there was a significant downward trend in hemoglobin content of blood with increasing age There was no significant social class difference in hemoglobin levels In the study of old pensioners in Sunderland, Smith (1957) reports 88 per cent of the women and 55 per cent of the men in a random sample as having hemoglobin levels below 90 per cent, the degree of anemia increasing with advancing age At the consultative health center in Rutherglen (Anderson, 1955) the second most frequent diagnosis among four hundred old persons referred by their general physician for a medicosocial assessment was microcytic hypochromic anemia De Grailly and Destrem (1953) state that in the healthy aged the blood is characterized by a certain amount of excess globulin with a decrease in hemoglobin Binet and Bourlière (1955) give as normal findings in the old hemoglobin values for men of 14 1 ± 1 53 g/100 g blood, and for women 13 7 ± 1 07 g/100 g blood as contrasted to normal adult values of 16 g/100 g blood in males and 14 g/100 g blood in females Howell (1950), however, after hemoglobin determinations on 52 male and 63 female patients over 60 years of age in a chronic disease hospital who were not suffering from known anemia chronic bronchitis, or new growths, concludes that the statement "old people are anemic" is incorrect as a general statement He found a wide range of hemoglobin values from 12 9 g to 23 3 g/100 ml in his subjects (standard 13 8 g/100 ml = 100 per cent hemoglobin), extending in the direction of greater hemoglobin content than less Brull (1954) states that age of itself does not lower hemoglobin and that it is necessary to exclude the presence of hypochromic anemia or pernicious anemia in aging persons

In neither the Wolverhampton (Sheldon, 1948) nor the Sheffield (Hobson and Pemberton, 1955) surveys were the old people with low hemoglobin values being treated for anemia As Stieglitz (1950) points out, anemia is of considerably more significance in old people, since their ability to readjust and to compensate for inadequacies declines The content and quality of blood assume a critical role in the presence or threat of circulatory insufficiency, and hemoglobin content needs to be maintained at an optimum level Because of the adverse effect of anemia in cardiac disease and on the course of cerebral arteriosclerosis, one simple hemoglobin determination in all old people would detect a potentially remediable cause of ill heath (Hobson and Pemberton, 1955)

BLOOD PRESSURE

Statistical analysis of clinical material reveals an interrelationship of hypertension, arteriosclerosis, and the aging process (Grollman, 1955) Loss of elasticity of the vascular tree due to arteriosclerotic changes in the blood vessels is reflected in a rise in systolic blood pressure and a small decrease in diastolic pressure, but this is not hypertension In the true hypertensive state there is not only an increase in systolic blood pressure but also a marked rise in diastolic blood pressure The fundamental disturbance here is caused by an increase in peripheral resistance due to alteration in function and loss of adaptability rather than to structural change In hypertensive cardiovascular disease there is also a concomitant rise of diastolic blood pressure with the rise of systolic blood pressure The experimental work of Grollman indicates that hypertensive cardiovascular disease is due to renal dysfunction Rise in diastolic pressure occurs when the arteriosclerotic process involves the renal blood vessels and is a direct result of an interference with the normal incretory (as distinct from excretory) function of the kidney responsible for maintaining the normotensive state In addition abiotrophic changes causing groups of glomeruli and complete nephrons to disappear occur in

the kidney in man This process produces the characteristic irregularity of contour of the senescent kidney and also contributes to the production of hypertension of increasing severity with age

Rise in systolic pressure alone, therefore is not true hypertension and may be present in many subjects who feel perfectly fit and capable of normal activity This is of extreme clinical importance in the management of old people since the treatment of blood pressure per se may provoke unnecessary anxiety and tension Hobson and Pemberton (1955) found no correlation of hypertension heart disease or high blood pressure with vertigo, tinnitus angina of effort clinically detectable arteriosclerosis or size of heart by X ray, and in spite of an elevated blood pressure subjects may be normally active and have a feeling of well being In Denmark Norgaard (1955) determined blood pressures of 2269 elderly persons ranging from 70 to 91 years of age all of whom were physically active many holding auto driver s licenses Among males ages 72–82 years of age he found blood pressures of 156 ± 30 systolic, over 89 ± 20 diastolic Among women in the same age group the mean value was 157 systolic over 89 diastolic. Male subjects 82 91 years of age had an average blood pressure value of 160 over 83 At the Rutherglen Consultative Health Centre (Anderson 1955) 186 out of 400 patients examined had blood pressures of 140/90 or over and of this number 109 had no symptoms of headache or vertigo while 77 had symptoms of headache or vertigo Of the subjects with no complaints 66 had a systolic pressure of over 170 and 13 had a diastolic pressure of over 110

Results of blood pressure surveys support the view that the significance of an elevated blood pressure must be assessed in light of the whole old person his physical state and symptoms and ability to function and that an increase in blood pressure per se should not be isolated as a target for treatment

MUSCULATURE AND SKIN

Histological studies of normal skin of individuals at various ages have not revealed any striking differences between age groups Except for atrophy in the epidermis and atrophic changes in the collagen fibers, there are no appreciable microscopic changes in the sebaceous or sweat glands, blood vessels nerves, or fat in the skin of the old (Vickers and Sneddon 1956) The skin changes that occur with aging seem to be due more to alteration of function than to anatomical changes A gradual decrease in the secretion of the sebaceous glands gives the skin a dull and dry appearance Senile pruritus, when not due to systemic disease and senile dermatitis are two frequent dermatological complaints of old people and are associated with dryness of the skin It is possible that alteration in hormonal secretion also might be a factor in producing skin changes and loss of hair or baldness The cause of graying of the hair is not understood but it is associated with a loss of pigment cells and is a hereditary characteristic.

In the natural aging process there is a reduction in the number and size of tissue cells with replacement by less specific elements like fat and connective tissue and a general loss of elasticity which is more obviously seen in the skin Muscle and strength wane, and the wrinkled and flab- [illegible]

in the normal and plus normal category when assessed for body build more men than women being in these categories. The surveys of Hobson and Pemberton (1955) in England and van Zonneveld (1954) in the Netherlands show a high proportion of physically fit old men and women in general women being less fit than men with unfitness rate rising with age

DIGESTION

Since the gastrointestinal tract undergoes involution and atrophy with age as

evidenced by diminution in acid secretion and digestive enzymes of the stomach and intestinal canal, some impairment in function is to be expected (Stieglitz, 1950) Sheldon and others found, however, that, unless systemic disease is present, the aged *follow a normal diet, enjoy food*, and eat the usual foods at the usual times Widdowson and McCance (1955) in Germany showed that old people respond to the stress of a sudden gross departure from *their previous food intake qualitatively* and quantitatively in the same way as young men, retaining sufficient elasticity of function to make exactly the same response whether they are faced with starvation or an abundance of food Sheldon (1948) states that, as only 18 8 per cent of his sample had digestive symptoms, one must respect the durability of the stomach Proper chewing and teeth are necessary for adequate digestion but again old people show a remarkable degree of adaptability In Sheldon s study there were no appreciable ill effects on digestion from defects of teeth Of his sample, 38 per cent had inadequate teeth for mastication including those who had dentures and did not use them as well as those with a few stumps or bare gums and no digestive symptoms The group having neither natural teeth nor dentures (14 4 per cent of the men and 7 7 per cent of the women) found no difficulty in eating even hard and tough foods on gums alone without any reflection on digestive function Hobson and Roseman (1953) also found patients chewing on gums alone and, among the 230 old persons examined could find no evidence that dietary intake or nutrition was affected adversely by poor dentition

Stieglitz (1950) stressed the importance of adequate ingestion of water Besides stimulating the flow of digestive juices which are necessary for good digestion, water is required for good bowel and kidney *function to help the body get rid of* the wastes of metabolism

RESPIRATORY SYSTEM

Morphologically, there is a decrease in the elastic tissue of the lungs and tracheobronchial tree which leads to fibrosis, with a reduced vital capacity, and produces the emphysematous barrel chest of the old person who suffers with shortness of breath. Most old people have a cough which varies from an occasional spasmodic cough, usually in the morning and often aggravated in the winter, to a more constant cough as age advances In the earlier years it is probably due to cardiovascular disease which is usually fatal by the age of 74 After that age it is more likely to be a true senile bronchitis ' Chronic bronchitis is a frequent concomitant of advancing years in western Europe, more common in England than on the Continent, and called in England the ' English disease " It may become a cause of disability, and, according to Brockington *(1957)*, its *maximum mortality* is between 65 and 80 years Shortness of breath or dyspnea is a serious symptom in old people because of its effect in restricting their movement It appears after the reserves of the body are used up and is most frequently the result of chronic bronchitis and emphysema and cardiac insufficiency

CENTRAL NERVOUS SYSTEM

Assessment of the central nervous system reveals a wide variation of findings which in apparently physically fit persons must set one on guard in making diagnoses of central nervous system disease Loss of tendon reflexes especially ankle jerks, may occur without any other evidence of cord lesions Findings such as absent pupillary reaction loss of superficial reflexes absent vibration sense in the sacrum lower limbs and dysmetria and patchy analgesia may be seen without any anatomical lesion to account for them and are the result of involution and deterioration in function that goes with senescence At the Rutherglen *Health Centre (Anderson 1955)* abdominal reflexes were absent in 55 6 per cent of

the subjects between 55 and 74 years and in 64 6 per cent of those aged 75 years and over Absent or diminished tendon reflexes were also noted in the absence of definite disease of the central nervous system

Slowing of sensorimotor performance is one of the most obvious and readily detected changes that occurs in aging Skills develop with practice and use After maximum attainment, efficiency in performance declines with age, noticeable even in early or late middle age This is due to changes in the peripheral organs as well as the central mechanisms of the brain (Welford 1956) The conduction time of nerve impulses increases with age and experiments have shown that there is a slowing in the central processes necessary to organize a complicated movement pattern (Singleton 1955) Older people lose some of their efficiency in anticipating the planning of a series of movements and must program one movement at a time The speed of visual perception also tends to diminish and a greater amount of light is required for visual stimulation as age increases Much can be done in research in industrial design and engineering to improve the efficiency of older people on the job or in everyday living at home by recognizing and providing against the limitations age imposes on performance

The results of intelligence tests reveal a parallel between decline in intellectual and sensorimotor function with increase in age However there is a wide overlap in performance of younger and older individuals many older persons scoring as well as or even better than the average of the younger subjects. There also seems to be somewhat less decline among the well endowed and people of superior attainments

Older people depend to a much greater extent on sensory stimulation particularly their eyes in performing tasks than do younger people (Szafran 1955) They are handicapped in situations where they are deprived of visual information and particularly when movements depend more on postural sense than on eyes Rigidity of the ciliary muscles in older individuals causes a loss in the power of accommodation Decline in the function of the central nervous mechanisms that give kinesthetic information subserving postural tone and orientation produces clinical problems of practical importance, notably a liability to falls Age groups show a steadily rising incidence of vertigo difficulty in the dark, and liability to falls, especially after 75 years. Sheldon (1948) found that, by the age of 80 73 per cent of females and 36.3 per cent of males were affected, but this seemingly greater susceptibility on the part of women than men to falls is probably due to a *greater exposure to risk* arising out of their housekeeping activities Falls are catastrophic occurrences in the lives of the elderly They often precipitate senile decay and are one of the most pernicious "previous illnesses" affecting the health of old people

VISION

The eye is an important organ in maintaining the old person in equilibrium with his environment, and much of the disability due to its dysfunction is readily remediable As age advances the individual relies more and more on visual information to reinforce proprioceptive cues, and tasks previously performed through habit or by touch alone come to require direct visual attention Visual acuity falls with age Studies show that a majority of old people need glasses for close work and that many who possess glasses either find them useless or are using glasses that are definitely harmful (Sheldon, 1948) An eye examination and provision of properly fitted glasses would prevent or relieve an avoidable source of disability for the elderly (Sheldon 1948, Hobson and Pemberton, 1955)

C *Vitality of Old People*

Planning for medical care is an important feature of the total program for the care of the aging population The old do not form a homogeneous group There are

evidenced by diminution in acid secretion and digestive enzymes of the stomach and intestinal canal, some impairment in function is to be expected (Stieglitz, 1950) Sheldon and others found, however, that, unless systemic disease is present, the aged follow a normal diet, enjoy food, and eat the usual foods at the usual times Widdowson and McCance (1955) in Germany *showed that old people respond to the* stress of a sudden gross departure from their previous food intake qualitatively and quantitatively in the same way as young men, retaining sufficient elasticity of function to make exactly the same response whether they are faced with starvation or an abundance of food Sheldon (1948) states that, as only 18 8 per cent of his sample had digestive symptoms, one must respect the durability of the stomach Proper chewing and teeth are necessary for adequate digestion, but again old people show a remarkable degree of adaptability In Sheldon's study there were no appreciable ill effects on digestion from defects of teeth Of his sample, 38 per cent had inadequate teeth for mastication, including those who had dentures and did not use them as well as those with a few stumps or bare gums, and no digestive symptoms The group having neither natural teeth nor dentures (14 4 per cent of the men and 7 7 per cent of the women) found no difficulty in eating even hard and tough foods on gums alone without any reflection on digestive function Hobson and Roseman (1953) also found patients chewing on gums alone and, among the 230 old persons examined, could find no evidence that *dietary intake or nutrition was affected ad*versely by poor dentition

Stieglitz (1950) stressed the importance of adequate ingestion of water Besides stimulating the flow of digestive juices which are necessary for good digestion, water is required for good bowel and kidney function to help the body get rid of the wastes of metabolism

RESPIRATORY SYSTEM

Morphologically, there is a decrease in the elastic tissue of the lungs and tracheo*bronchial tree which leads to fibrosis*, with a reduced vital capacity, and produces the emphysematous barrel chest of the old person who suffers with shortness of breath Most old people have a cough, which varies from an occasional spasmodic cough, usually in the morning and often aggravated in the winter, to a more constant cough as age advances In the earlier years it is probably due to cardiovascular disease which is usually fatal by the age of 74 After that age it is more likely to be a true senile *bronchitis* '*Chronic bronchitis*' is a frequent concomitant of advancing years in western Europe, more common in England than on the Continent, and called in England the '*English disease*" *It may become* a cause of disability, and, according to Brockington (1957), its maximum mortality is between 65 and 80 years Shortness of breath or dyspnea is a serious symptom in old people because of its effect in restricting their movement It appears after the reserves of the body are used up, and is most frequently the result of chronic bronchitis and emphysema and cardiac insufficiency

CENTRAL NERVOUS SYSTEM

Assessment of the central nervous system reveals a wide variation of findings which in apparently physically fit persons must set one on guard in making diagnoses of central nervous system disease Loss of tendon reflexes, especially ankle jerks, may occur without any other evidence of cord lesions Findings such as absent pupillary reaction loss of superficial reflexes, absent vibration sense in the sacrum lower limbs and dysmetria, and patchy analgesia may be seen without any anatomical lesion to account for them and are the result of involution and deterioration in function that goes with senescence At the Rutherglen Health Centre (Anderson, 1955) abdominal reflexes were absent in 55 6 per cent of

the subjects between 55 and 74 years and in 64 6 per cent of those aged 75 years and over Absent or diminished tendon reflexes were also noted in the absence of definite disease of the central nervous system

Slowing of sensorimotor performance is one of the most obvious and readily detected changes that occurs in aging Skills develop with practice and use After maximum attainment, efficiency in performance declines with age, not on [illegible]

tral mechanisms of the brain (Welford, 1956) The conduction time of nerve impulses increases with age, and experiments have shown that there is a slowing in the central processes necessary to organize a complicated movement pattern (Singleton 1955) Older people lose some of their efficiency in anticipating the planning of a series of movements and must program one movement at a time The speed of visual perception also tends to diminish and a greater amount of light is required for visual stimulation as age increases Much can be done in research in industrial design and engineering to improve the efficiency of older people on the job or in everyday living at home by recognizing and providing against the limitations age imposes on performance

The results of intelligence tests reveal a parallel between decline in intellectual and sensorimotor function with increase in age However there is a wide overlap in performance of younger and older individuals many older persons scoring as well as or even better than the average of the younger subjects There also seems to be somewhat less decline among the well endowed and people of superior attainments

Older people depend to a much greater extent on sensory stimulation, particularly their eyes, in performing tasks than do younger people (Szafran, 1955) They are handicapped in situations where they are deprived of visual information and particularly when movements depend more on postural sense than on eyes Rigidity of the ciliary muscles in older individuals causes a loss in the power of accommodation Decline in the function of the central nervous mechanisms that give kinesthetic information subserving postural tone and orientation produces clinical problems of practical importance, notably a liability to falls Age groups show a steadily rising incidence of vertigo, difficulty in the dark, and liability to falls, especially after 75 years Sheldon (1948) found that, by the age of 80, 73 per cent of females and 36.3 per cent of males were affected, but this seemingly greater susceptibility on the part of women than men to falls is probably due to a greater exposure to risk arising out of their housekeeping activities Falls are catastrophic *occurrences in the* lives of the elderly They often precipitate senile decay and are one of the most pernicious "previous illnesses" affecting the health of old people

VISION

The eye is an important organ in maintaining the old person in equilibrium with his environment, and much of the disability due to its dysfunction is readily remediable As age advances, the individual relies more and more on visual information to reinforce *proprioceptive cues*, and tasks previously performed through habit or by touch alone come to require direct visual attention Visual acuity falls with age Studies show that a majority of old people need glasses for close work and that many who possess glasses either find them useless or are using glasses that are definitely harmful (Sheldon, 1948) An eye examination and provision of properly fitted glasses would prevent or relieve an avoidable source of disability for the elderly (Sheldon 1948, Hobson and Pemberton, 1955)

C *Vitality of Old People*

Planning for medical care is an important feature of the total program for the care of the aging population The old do not form a homogeneous group There are

the healthy and self reliant, the frail, the incapacitated, the chronically ill, the lonely—each group with a different need In planning medical care for an increasing old age population, it is important to know the state of health of old people, the frequency with which they fall ill, from what causes, and what their medical needs are

Many medical surveys have been done in a variety of communities to determine the state of health of old people living at home and have contributed to our knowledge of the health and needs of old people

1 *Wolverhampton survey*—This pioneer medical survey followed a social study (Rowntree, 1947) in the same community and was undertaken by Sheldon for the Nuffield Foundation on a random sample of 477 persons 60 years of age and over living at home from May, 1945 to January, 1947 The report by Sheldon (1948) is a classic document which drew attention to old people in Western society as individuals with a medical and social past and present and with definite needs that must be met if the increasing number of old people in the community is to be provided for adequately in the future

If activity and a feeling of physical fitness are measures of the state of health the power of adaptation in those who survive to old age must be considerable Sheldon found in his survey of old people that many preserve a remarkable amount of physical sturdiness When assessed in respect to state of health 46 2 per cent of the old people were 'normal Since more than this percentage complained of particular symptoms, the old person can carry on adequately in spite of several and sometimes considerable, complaints More women than men were in this group Since knowledge of "normal' at present is confined to the years of growth and maturity and the changes and rate of change from maturity to senescence are still largely unknown, "normal" as Sheldon defined it was based on his standard of "elastic common sense"

The group classified "normal plus" comprised 24 5 per cent of the sample, and the men and women in it showed remarkable vigor and hardiness More men than women were in this group Men tend to die earlier, but those who attain advanced ages are of particularly good fiber and in very good physical health

The "subnormal' group was made up of 29 2 per cent of the sample There was an equal number of men and women in this group However, 62 5 per cent of the 'subnormal' women were over 85 years of age while the bulk of the "subnormal men (81 6 per cent) were below 80 years of age The whole group is remarkable for its persistence in carrying on in spite of severe or painful defects of health, the women especially seeming to have a tenacious hold on life and continuing to survive in spite of chronic ill health

In this survey only 2 5 per cent of the old people living at home were confined to bed 8 5 per cent were confined to the house, and the movements of 22 5 per cent of the sample were restricted to the neighborhood

Only a small percentage of the aged require medical care for sickness The larger need of older persons is for services that will help them to remain at home in familiar surroundings where the risk of deterioration and disability is considerably less

2 *Sheffield survey*—Hobson and Pemberton (1955) undertook a similar survey to assess the health of a random sample of 476 persons 61 years of age and over living at home in the Sheffield area A previous study of the social circumstances and needs of old people in Sheffield had been made by the Sheffield Council of Social Service in 1948 (Greenlees and Adams 1950) The medical survey revealed a high proportion of elderly men and women who appear to remain more or less unrestricted in activity Women seemed rather less fit than men (54 9 per cent of females as against 71 2 per cent of males being unrestricted in activity), and age for age there were more disabilities among elderly women than elderly men Just over 50 per cent of the

total sample regarded themselves as fit but only 25 per cent of them were assessed as fit by the physician after examination In both sexes, disablement increased with age, however, in the higher age groups there was a considerable number of very fit men and women Ill health in old age is to some extent related to poverty Mean disablement scores tended to be higher in those on low incomes and were significantly higher among those living in the poor neighborhoods as compared with those living in the better residential areas of Sheffield Mean disablement scores of men who had retired did not differ significantly from scores of those still working at similar ages suggesting that retirement usually occurred for reasons other than ill health

3 *Groningen survey*—Van Zonneveld (1954) reported a survey of old people undertaken by the University's Department of Preventive and Social Medicine in the city of Groningen (Netherlands) which has a diversified population of farmers laborers and industrial workers The purpose of the survey was to assess the physical and mental state of the old people and the way they adapted to their ailments, to find out how they were being cared for, and to get some idea of the best possible provision for them from a sociomedical viewpoint Three thousand persons 65 years and over (one-fourth of the entire aged population of the city) were included in the survey The older person estimated his own state of health and in every age group more than 80 per cent of the men and about 74 per cent of the women had no special complaints of health. Although more women than men complained about health the number of those who complained did not increase with advancing years, and there was no significant difference in complaints about health based on social class Men who were still working complained less about health than those who had stopped working About 8 per cent of those between 65 and 70 years and 40 per cent of those 80 years and over lived dependently However, about 3 7 per cent of the old people were in need of home help An interesting finding was that six parents of individuals in the study were still alive at the time of the survey

4 *Study of the aged by general practitioners in the Netherlands begun in 1953*— Another investigation reported by van Zonneveld and Groen (1957) is still under way and covers random samples of more than 95 per cent of all the aged in the Netherlands Preliminary information collected from 1000 forms shows that three fourths of the men and two thirds of the women considered themselves in a good state of health, although subsequent examination by a physician found fewer than this number in a good state of health Within the 3 months before the investigation two-fifths of the men and three fifths of the women had consulted their doctor, and the same proportion were attending their doctors regularly

D Common Disorders of the Aged

The disorders of old age do not seem to have changed with time Hippocrates (1943) characterized old men as suffering from "difficulty of breathing, catarrh accompanied by coughing strangury, difficult micturition, pains at the joints, kidney disease dizziness, apoplexy, cachexia, pruritis of the whole body, sleeplessness, watery discharge from the bowels, eyes and nostrils dullness of sight, cataract, hardness of hearing" Medical surveys show that first heart disease, then arthritis, followed by chronic bronchitis painful feet, urinary disorders, vertigo and defective hearing and vision are the chief causes of disability leading to restriction of motion and loss of independence of old people The following data are derived from the W[illegible] oth [illegible] in [illegible] persons over 60 years of age They reveal the disorders which occur frequently among old people

1 *Bronchitis*—Evidence of bronchitis was reported in 40 9 per cent of the sam

ple, more frequently in males than females, and varied from an occasional spasmodic cough in winter to the constant cough of a true senile bronchitis in the more aged subjects

2 *Heart disease*—Under the method of survey the extent of cardiac illness was not accurately determinable, but 5 per cent of the sample was estimated to have cardiac defects leading them to consult a doctor Unless the patient suffered a thrombosis with pain or edema, he did not bother to see the doctor This was also true for patients with angina of effort and edema of the feet, who carried on, modifying their activity as was necessary, in spite of symptoms Evans (1956) states that "patients over 70 years of age should be considered to have some cardiac impairment even though there may be no demonstrable cardiac disease"

3 *Hypertension*—Of the sample, 9 4 per cent were under, or had been under, treatment for high blood pressure Observations in this survey also show that rise in systolic blood pressure is compatible with a feeling of well being and normal activity

4 *Dyspnea or shortness of breath*—This is a serious symptom, second in importance to senile weakness, in causing discomfort and loss of independence for old people It is most frequently the result of respiratory embarrassment and circulatory insufficiency and is an indication of depleted body reserves In the Groningen survey (van Zonneveld, 1954) dyspnea and a sense of suffocation were common complaints occurring more frequently among women than men and among those of lower than higher social class

5 *Rheumatic affections*—Over half the sample (55 4 per cent) had rheumatic symptoms varying from twinges of muscular pain to crippling incapacity of joints Women were affected more than men, and, because of their responsibility for housework and often the care of a family, the effect of arthritis of the knee joints, usually menopausal, was a particular hardship especially where obesity was an added handicap The large number of persons with arthritis of varying types and extent who were still capable of unlimited movement affirmed the endurance and determination of the aged In classifying their sample for degree of mobility, Hobson and Pemberton (1955) remarked "It would be a mistake to assume that all those with unrestricted activity were fit and well It was simply a refusal to give in to the aches and infirmities of age that allowed many still to be classified 'mobility unrestricted' The types of rheumatic affections were (*a*) rheumatoid arthritis, which produced in some instances complete immobility of hand and wrist, (*b*) osteoarthritis of the hip and other joints, and (*c*) spondylitis This last, a genuine phenomenon of old age which results from senile changes in the spine, is slowly progressive and sometimes so severe as to produce a doubling up of the body Its incidence rises abruptly after the age of 80 years Some old people are able to carry on but spondylitis usually causes great disability especially when other symptoms are present

6 *Varicose veins*—Of the sample, 60 per cent all under 80 years of age suffered with varicose veins which were an important cause of "bad legs" Ulcers were present as a complication in 5 4 per cent of these cases

7 *Weakness*—Although difficult to differentiate from weakness associated with cardiac disease, 12 1 per cent of the sample seemed to suffer from a true senile weakness which caused considerable incapacity It is considered a definite clinical entity and is greater the older the age group especially among women after the age of 75 Its importance in geriatrics lies in the increasingly serious restriction it imposes on the activity of old people as age advances

8 *Genitourinary symptoms*—Frequency and urgency of micturition were found in 31 5 per cent of the sample and was greater among women than men In males it is largely due to prostatic obstruction, in

females it is the result of postpartum trauma to the pelvic floor, chronic cystitis, strain, coryza, cold weather, or senile weakness of the sphincter of the urethra In the Groningen survey (van Zonneveld, 1954) nocturia and dysuria were frequent complaints, more frequent among men than women True incontinence was rare among the elderly at home Incontinence, urinary or fecal, occurring as a result of stroke, pelvic operation, or senile weakness, is one of the distressing aspects of geriatric medicine It causes strain in the household in terms of patient care and linen care, becomes a barrier to social contacts for the old person, and is one of the most frequent reasons that lead families to seek institutional care for an aged member

9 *Defects of vision and hearing*—Of the sample 6.3 per cent had normal vision without glasses and enjoyed vigorous health and 12 3 per cent had diseases of the eye—1 per cent was totally blind, 5 6 per cent had cataracts and many had corneal opacities Almost 3 per cent needed glasses but did not have them, and one third of the sample found their present glasses unsuitable Sheldon found a distinct correlation between economic level and the likelihood of having unsuitable glasses The ignorance among old people of the true nature of glasses was evidenced by the fact that 10 per cent had come by their glasses in a haphazard way—either as a gift or inheritance or by purchase in a store simply by trying on glasses until one was found that gave a satisfactory magnification A proper eye examination had never been done among 17 5 per cent of those with glasses The number of old people with defective vision who possessed either useless or definitely harmful glasses indicate a service that could easily remove a source of disability for the aged

In the Groningen survey (van Zonneveld, 1954), 87 per cent of males and 79 5 per cent of females could see well with or without glasses In the entire sample about 1 7 per cent of the males and about 1.3 per cent of the females could see neither near nor far and used no glasses, and in the entire group 6 9 per cent of the males and 12 7 per cent of the females found their glasses of no use More females than males had complaints referable to the eye After the age of 80 years, only 25 per cent of the old people had no complaints of the eye or ear

Sheldon found that 31 per cent of the sample had evidence of defective hearing With advancing age, the efficiency of function of the inner ear declines, more so in men than women At age 80 and over the incidence of severe deafness is 60 per cent Tinnitus was also present in 17 8 per cent of the sample queried on this symptom In the Groningen survey (van Zonneveld, 1954), in the oldest age group 26 per cent of the males and 32 per cent of the females had perfect hearing The increasing association of vertigo and liability to fall, deafness and advancing age suggests that the inner ear, labyrinth, and central connections do not wear as well as other organs Since many old people with moderate deafness had a defect only in one ear (about 25 per cent), it would seem that one third of the old age population might benefit from the use of hearing aids The use of glasses and a hearing aid could frequently mean the difference between dependency and unsociability and the ability to get about and lead a useful life

10 *Vertigo and liability to fall*—Vertigo was present in 51 6 per cent of the sample and was greater among women than men It may be due to changes in blood pressure, diseases of the ear, or senile degeneration of the labyrinth Vertigo and deafness are usually associated Of the 26 subjects who complained of tinnitus, 22 also had vertigo It would appear that the whole labyrinthine apparatus and cochlea are prone to senile degeneration, which increases as age advances, becoming particularly pronounced at age 80

Advancing age groups also show a steadily rising liability to falls, associated with an increasing incidence of deafness, difficulty in the dark, and vertigo The in

cidence is particularly high in women—73 per cent of women over the age of 80 were liable to fall This poses a serious clinical problem of practical importance, since falls often precipitate senile decay Sheldon found falls the second most important previous illness affecting present health in his subjects Howell (1956) found the chief reasons for falls among the old people he interviewed at home to be unsuspected cerebral thrombosis, degeneration of the posterior columns of the spinal cord, senile muscular weakness, vertigo, and impaired vision

Movements of old people are handicapped in circumstances where they are forced to depend more on postural sense and less on the eye Although there might be psychological aspects to the difficulty old people experience with their vision at night, most cases of difficulty in the dark are due to a senile failure in mechanisms serving posture and orientation, in which the labyrinth plays an important part Szafran (1955), of Cambridge, corroborated Sheldon's observation that direct visual information is of much greater importance in middle and later life in performing tasks Beyond age 75, mechanisms subserving postural tone are liable to fail suddenly in function In maintaining balance, the labyrinth supplies information on the position of the body in space which is supplemented by information from the eyes, muscles and joints of the body In old age labyrinthine as well as central nervous system mechanisms that provide kinesthetic information decline These changes result in an increased liability to trip over trivial objects and to greater difficulty in recovering from even slight disturbance of balance

11 *Difficulty with stairs* —This is not a clinical illness but is a great handicap and source of difficulty for old people Sheldon found that 38 5 per cent of the sample had difficulty in negotiating stairs Ascending stairs was a greater source of difficulty than descending them 14 4 per cent had difficulty ascending stairs because of dyspnea, angina, or intermittent claudication, 5 per cent had difficulty in getting down steps, owing to diseases of the knee or hip stiffness of leg or feet, vertigo, faulty vision, or lack of confidence, 19 per cent had difficulty both ways, and 6 3 per cent found stairs impossible to negotiate Severe impairment of mobility was more frequently the result of recovery from stroke

Of the women having difficulty with stairs, 78 per cent were either partially or wholly responsible for their own housekeeping, and 10 per cent of those looking after an old person had trouble with stairs However, only half the old people having trouble with stairs were willing to leave their homes to avoid this difficulty The Nuffield Social Survey on old people recommends that "stairs should be wide and shallow, and should have a hand rail on both sides" (Rowntree, 1947)

12 *Other disorders of the aged* —Mortality statistics suggest that diabetes and tuberculosis are no longer major medical problems of the aged Diabetes is a relatively mild disease in the aged and is easier to control than in the younger individual However, its frequent association with peripheral vascular disease and the attendant complications constitutes a threat to the well being of the aged

Tuberculosis is not the killer it was before the successful use of chemotherapy in its control In the Scandinavian countries tuberculosis is no longer a serious health problem and many of the sanatoria and dispensaries that were previously required for the care of tuberculosis patients have been converted to care for old people A program for the aged in Norway has been developed by the Old People s Health Committee The National Tuberculosis Association, which has developed an interest in geriatry and heart disease, is an active participant of the Old People's Health Committee

In Belgium, Clerens (1956) has pointed out the flagrant difference between morbidity and mortality rates in tuberculosis among the aged as a result of drug therapy and the potential danger of the treated

chronic case as a carrier of resistant bacilli The need in Brussels for isolating infectious cases has tripled the need for hospital beds since the war, and a greater number of these patients are over 50 years of age The report of the Committee on the Care of the Chronically Ill and the Aged at the Ninth Congress of the International Federation of Hospitals recommended basing the need of beds for the care of chronic tuberculosis on the number of those sick, rather than the death rate, since in a number of countries the trend in morbidity does not parallel the trend in mortality (Delore, 1955, 1956*a*) Tuberculosis always remains a possibility in the differential diagnosis of a chronic cough in the old person. An incompletely healed foci within an apparently calcified area radiologically, or a long dormant infection are potential sources of reinfection When the immune mechanisms and vigor of the older person decline, these areas light up causing active disease which requires hospitalization for treatment

Diseases of the nervous system fall into two overlapping groups those associated with behavioral changes which require the help of a psychiatrist in dealing with them, and those associated with organic lesions, which fall in the domain of the neurologist. They are often secondary to vascular degeneration or to neoplastic changes in the central nervous system and account for some of the main chronic illnesses of old age Howell (1956) in an assessment in the homes of 509 older patients awaiting hospital admission found cerebral thrombosis or hemiplegia the commonest diagnoses, affecting 11 per cent of the old people, with senility accounting for 10 per cent of the diagnoses

Early recognition and treatment of illnesses, especially those that might restrict movement *are important* in preventing disability in the aged Up to the age of 70 years the pathological conditions that produce incapacity and restrict movement are the same as at all adult ages After age 70 the chief causative factors of restricted movement are more specific symptoms of aging—weakness, vertigo, difficulty with traffic, lack of confidence, spondylitis, and sensitiveness to cold Other conditions, such as arthritis, painful feet, defective vision, angina, and mechanical disabilities from previous accidents, may also cause great impairment of function

Tables 1–5 show the admission or discharge diagnoses of old people from various institutions in several countries

Social care has to be related to medical needs, and, in planning housing and other community services for the aged, it must be remembered that the people utilizing these facilities may suffer with these medi

TABLE 1*

DIAGNOSES AMONG 400 PATIENTS 54 YEARS AND OVER ATTENDING THE CONSULTATIVE HEALTH CENTRE AT RUTHERGLEN, SCOTLAND

Disease	Male	Female	Total
Blood pressure 140/90 or over			
(1) With no symptoms of headache or vertigo	62	47	109
(2) With symptoms of headache or vertigo	28	49	77
Blood pressure less than 140/90 with no symptoms	5	3	8
Microcytic hypochromic anemia	14	18	32
Osteoarthritis	15	16	31
Fibrositis	3	24	27
Chronic bronchitis	18	4	22
Coronary artery disease (previous coronary thrombosis)	11	4	15
Tumor—malignant	5	4	9
Intermittent claudication	10		10
Valvular heart disease			
(1) Rheumatic	1	3	4
(2) Arteriosclerotic	2	1	3
(3) Syphilitic	1		1
Diabetes mellitus	2	3	5
Pernicious anemia	1	2	3
Angina pectoris	1	2	3
Miscellaneous	24	17	41
Total	203	197	400

* After W F Anderson, A Clinical Study of the Patients Attending a Consultative Health Center for Old People at Rutherglen, Scotland, in *Old Age in the Modern World* (Edinburgh E & S Livingstone, 1955) p 537

cal conditions All measures that protect the health and preserve the mobility of old people should be developed and integrated *in a program of total care to help them maintain their integrity and independence* as fully functioning social individuals in the community.

TABLE 2*

PROVISIONAL DIAGNOSIS IN 4622 CHELSEA PENSIONERS ADMITTED FOR TREATMENT TO THE INFIRMARY OF THE ROYAL HOSPITAL

Disease	Per Cent
Bronchitis	13.5
Old age debility	11.6
Myocardial degeneration	9.5
Influenza	7.8
Digestive disorders	7.7
Rheumatic diseases	6.1
Other cardiovascular diseases	6.1
Central nervous system lesions	5.1
Pneumonias	3.1
Cancer	4.3
Genitourinary	3.4
Other diseases	21.7
Total	100.0

* After T H Howell *Old Age* (London H K Lewis & Co 1950), p 85

TABLE 3*

DIAGNOSES IN 1100 PATIENTS 65 YEARS AND OVER ADMITTED TO A GENERAL MEDICAL SERVICE FROM 1952 TO 1956 (REPRESENTING 28.4 PER CENT OF ALL PATIENTS ADMITTED DURING THE SAME PERIOD)

Illness	No of Patients	Per Cent
Cardiovascular	240	21.8
Respiratory	238	21.6
Neuropsychiatric	162	14.7
Nutritional	130	11.8
Senility	117	10.6
Gastrointestinal	80	7.3
Liver, bile duct, pancreas	72	6.5
Rheumatism	61	5.6
Genitourinary	39	3.5
Skeletal	31	2.8
Blood	15	1.4
Skin	13	1.2
Endocrine	9	0.8
Others	45	4.1

* After P Delore and P Arnaud "Mot [illegible] hospitalisation des malades âgés de plus de 65 ans" *Tech Hosp*, 11 (August September 1956), 48 53

TABLE 4*

DIAGNOSES IN 243,730 PATIENTS 60 YEARS AND OVER ADMITTED TO HOSPITALS IN ITALY, 1954

Disease	Total No Patients All Aged	Patients 60 Years and Over	
		No	Per Cent
Circulatory system	87,723	33,527	38.2
Nervous system	83,431	29,768	35.6
Tumors	100,259	28,999	29.0
Psychotic disease	49,385	8,556	17.4
Skin diseases	47,929	7,972	16.6
Genitourinary system	109,913	17,931	16.3
Bones, etc	47,966	7,091	15.0
Accidents	259,547	34,573	13.3
Digestive system	401,132	36,746	9.2
Respiratory system	179,273	15,652	8.7
Infectious	156,332	9,748	6.2

* Source Personal communication from *Professor* C A Canaperia 1957

TABLE 5*

DIAGNOSES AT DISCHARGE OF PATIENTS 65 YEARS OR MORE IN SIXTEEN HOSPITALS (JANUARY 15 AND/OR APRIL 15, JULY 15 AND OCTOBER 15, 1954) IN THE NETHERLANDS

(N = 2441 Men and 2358 Women)

Disease	Per Cent	
	Males	Females
Malignant neoplasm	17	15
Prostatic hypertrophy	14	
Heart	10	13
Accidents	9	13
Vascular	6	7
Hernia of the abdominal cavity and ileus	5	2
Diabetes	4	11
Gastric and duodenal ulcers	4	3
Urinary tract	4	
Liver and gall bladder and biliary ducts	4	11
Mental	4	4
Eye	4	4
Bone and other organs of locomotion	3	6
Hypertension	2	5
Cerebrovascular lesions	2	2

* After H J Bronts and R J van Zonneveld, "The Impact [illegible]

E Mortality and Morbidity in Old Age

CAUSES OF MORTALITY IN OLD AGE

People who survive to old age do not die of old age They die from disease, and, as Vischer and Roulet's (1952) post mortem report indicates, usually a multiplicity of morbid processes are found on autopsy Biological death is exceedingly rare, and, according to Gavey (1949), when this does take place, the heart is usually the primary causes of mortality have been reduced, there has been very little decrease in mortality from disease of the circulatory system, tumors, and senility

Also on the increase is the death rate from cancer (Table 8) The death rate of older males from tuberculosis (Table 9) had increased in three of the leading European countries reported and for females in two Other countries showed a moderate decline This is in sharp contrast with the

TABLE 6*

AGE ADJUSTED DEATH RATES PER 1000 FOR AGE GROUPS 45–64 AND 65 AND OVER BY SEX FOR ABOUT 1930 AND 1950†

Country	1930				1950			
	45–64		65 and Over		45–64		65 and Over	
	Male	Female	Male	Female	Male	Female	Male	Female
England and Wales	16 6	12 1	90 1	70 8	14 5	8 4	81 1	59 3
Australia	14 1	10 1	74 5	59 7	14 4	8 7	79 1	57 3
Canada	13 2	11 8	70 9	64 5	12 9	8 5	63 8	53 4
Netherlands	11 7	11 4	72 6	69 4	9 1	7 2	61 8	57 6
Belgium	16 9	12 6	83 9	71 6	15 0	9 1	76 7	61 4
France	20 4	13 2	97 0	79 2	14 9	8 5	77 2	54 2
Switzerland	19 1	13 1	89 0	76 7	13 2	8 5	74 7	60 8
Germany	14 6	12 1	80 7	74 4	12 6	8 6	72 2	64 6
Denmark	12 6	12 0	73 7	71 6	10 3	8 2	67 5	62 7
Norway	12 0	9 9	64 6	58 3	8 9	6 5	59 4	51 7
Sweden	12 7	11 3	70 5	67 2	10 0	7 8	67 2	60 7
Finland	23 3	13 8	83 6	71 3	19 5	9 3	87 0	68 8
Italy	15 2	12 0	80 9	73 5	12 5	8 2	66 3	58 8

* After M Spiegelman [illegible]
1954 [illegible]

factor Some degree of arteriosclerosis and emphysema seems to be a "normal" finding in the aged The risk of degenerative disease is the price of longevity Spiegelman (1954)

[illegible] countries included in Table 6 but are still about five to six times higher than for adults 45–64 The death rate from cardiovascular renal disease is increasing and is now the leading cause of mortality in old age (Table 7) Freudenberg (1955) has shown that in Germany, although other

mortality rate for this disease for the age group 45–64, which showed consistent declines, generally large, for both sexes and all countries Six of the ten European countries show a drop, generally a steep one, in pneumonia, while the others show a small rise for one or both sexes (Table 10)

Cancer is becoming an increasingly important cause of mortality The incidence of tumors increases with age As age increases, however, the rapidity of growth and the malignancy of tumors decrease, especially after the period of highest can

TABLE 7*

DEATH RATE PER 100,000 FROM CARDIOVASCULAR RENAL DISEASE FROM SELECTED COUNTRIES, *ca* 1931 AND *ca* 1949†

COUNTRY	AGES 45–64				AGES 65 AND OVER			
	1931		1949		1931		1949	
	Male	Female	Male	Female	Male	Female	Male	Female
England and Wales	565	443	565	350	4133	3608	4399	3864
Australia	509	396	785	460	3233	2775	4512	3598
Canada	437	409	694	395	3270	3204	4037	3643
Netherlands	335	366	317	263	2762	2980	2885	3154
Belgium	547	438	587	379	2947	2580	3449	2994
France	563	397	474	332	2786	2219	3793	2896
Switzerland‡	877	830	823	615	4632	4773	4963	4831
Germany			366	285			2813	2767
Denmark	367	321	393	275	2704	2861	3350	3468
Norway‡	543	461	530	403	3288	3024	3736	3592
Sweden‡	547	521	644	514	3914	3756	5044	4970
Finland	662	431	851	439	1759	1503	4055	3297
Italy	463	461	415	341	3486	3375	3340	3205

* After M. Spiegelman, "An International Comparison of Mortality Rates at the Older Ages" in *World Population Conference, 1954, Papers* (Geneva: United Nations, 1954), 1, 306.

† Death rates not adjusted for age.

‡ For these countries age group as indicated:

Switzerland	50–69	70 and Over
Norway	50–69	70 and Over
Sweden	45–69	70 and Over

TABLE 8*

DEATH RATE PER 100,000 FROM CANCER FOR SELECTED COUNTRIES *ca* 1931 AND *ca* 1949

COUNTRY	AGES 45–64				AGES 65 AND OVER			
	1931		1949		1931		1949	
	Male	Female	Male	Female	Male	Female	Male	Female
England and Wales	293	298	322	261	1111	886	1167	808
Australia	212	225	207	224	976	720	1001	750
Canada	197	264	227	257	839	748	1005	810
Netherlands	248	312	242	255	1189	999	1136	977
Belgium	187	239	221	234	626	592	762	679
France	182	194	248	223	551	490	1029	760
Switzerland†	549	405	482	358	1485	1100	1625	1053
Germany			257	263			1113	947
Denmark	245	303	228	268	1077	1085	1042	963
Norway†	390	369	307	306	1211	960	1397	1025
Sweden†	291	308	236	268	1016	840	1081	895
Finland	198	197	393	250	524	401	1303	902
Italy	172	186	243	206	491	437	754	605

[illegible] in World Population Conference [illegible]

Switzerland	[illegible]	[illegible]
Norway	50–69	70 and Over
Sweden	45–69	70 and Over

TABLE 9*

DEATH RATE PER 100,000 FROM TUBERCULOSIS FOR SELECTED COUNTRIES *ca* 1931 AND *ca* 1949

COUNTRY	AGES 45–64				AGES 65 AND OVER			
	1931		1949		1931		1949	
	Male	Female	Male	Female	Male	Female	Male	Female
England and Wales	151	58	104	28	73	40	81	22
Australia	112	44	81	18	97	45	121	29
Canada	90	61	56	27	99	81	80	44
Netherlands	82	71	42	27	112	94	87	81
Belgium	115	46	111	23	73	49	73	34
France	265	100	153	50	126	73	150	81
Switzerland†	187	133	83	38	199	217	124	105
Germany			91	30			124	69
Denmark	63	49	30	12	74	62	40	37
Norway†	136	116	68	28	138	110	83	53
Sweden†	120	101	55	30	104	105	78	57
Finland	305	170	262	67	171	112	313	121
Italy	129	88	91	32	72	63	55	37

* After M. Spiegelman, "An International Comparison of Mortality Rates at the Older Ages," in *World Population Conference, 1954 Papers* (Geneva: United Nations, 1954) I, 306.

† For these countries age group as indicated

Switzerland	50–69	70 and Over
Norway	50–69	70 and Over
Sweden	45–69	70 and Over

TABLE 10*

DEATH RATES PER 100 000 FROM PNEUMONIA AND INFLUENZA FOR SELECTED COUNTRIES, *ca* 1931 AND *ca* 1949

COUNTRY	AGES 45–64				AGES 65 AND OVER			
	1931		1949		1931		1949	
	Male	Female	Male	Female	Male	Female	Male	Female
England and Wales	169	96	65	34	494	474	353	296
Australia	102	64	47	21	489	402	374	282
Canada	86	68	33	18	525	621	285	262
Netherlands	112	96	39	33	996	1031	458	492
Belgium	112	83	41	20	515	497	259	220
France	102	68	41	28	507	486	549	490
Switzerland†	192	165	31	25	1225	1241	363	383
Germany			37	27			351	335
Denmark	75	66	28	24	549	378	532	554
Norway†	123	114	43	45	773	840	729	871
Sweden†	131	147	29	22	978	1113	336	387
Finland	109	69	45	28	247	227	278	279
Italy	234	165	54	31	1035	986	452	390

* After M. Spiegelman "An International Comparison of Mortality Rates at the Older Ages" in *World Population Conference, 1954 Papers* (Geneva: United Nations, 1954) I, 306

† For these countries age group as indicated

Switzerland	50–69	70 and Over
Norway	50–69	70 and Over
Sweden	45–69	70 and Over

cer mortality, and vigorous therapy should be directed against the tumor consistent with the requirements of the case irrespective of age

MORBIDITY AMONG THE AGED

It is important to know the incidence of disease in the aged in order to plan intelligently for the medical and social services they require Sheldon's (1948) survey in Wolverhampton showed that 29 per cent of the subjects were receiving medical attention at the time of survey Hobson and Pemberton (1955), in the Sheffield survey found that about 47 per cent of the old people were receiving medical attention every 3 months or more often In the general practitioners' survey in the Netherlands (van Zonneveld and Groen 1957) 40 per cent of the men and 60 per cent of the women were receiving medical attention regularly at the time of survey The same proportion had consulted their doctors within 3 months prior to the investigation

In Britain the Monthly Survey of Sickness conducted by the Ministry of Health (1951–52) reports "ill defined symptoms" the most frequent complaint of persons over 65 years, with rheumatism next In the fall of 1957 a national survey on morbidity on a random sample of 75,000 families was started in Italy This study should provide some interesting facts about illnesses and illness rates among the older aged members of these families (Canaperia, personal communication) There is a need for more morbidity studies in the general population to furnish a total picture of the nature and extent of illness among the aged At the present time almost the only source of information outside reportable diseases on the prevalence of illness and disability is hospital records These do not give a true picture of morbidity from all diseases including the less serious and non disabling illnesses which is a prerequisite for setting up health services that will meet the over all needs of the aging

TABLE 11*

PATIENT POPULATION † ALL DISEASES AND CONDITIONS REQUIRING CONSULTATIONS ‡ IN EIGHT PRACTICES FOR THE PERIOD APRIL 1951—MARCH 1952 BY AGE AND SEX

AGE GROUP	POPULATION—ALL EIGHT PRACTICES		CONSULTATIONS—ALL PRACTICES			
			No		Rate per 100 Practice Population	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
0–14	3 135	3 138	11 862	12 149	353	363
15–44	4 787	6 456	13 741	26 591	268	386
45–64	2 352	3 187	10 083	15 913	399	468
65 and over	1 031	1 488	5 114	9 286	460	582
Not stated	824	967				
All ages	12 129	15 236	40 800	63 939	336	420

* After W P D Logan *Studies on Medical and Population Subjects* (General Practitioners Records No 7 [London H M Stationery Office 1953]) pp 41 and 85

† Patients consulting are the numbers consulting for each specified disease and are not aggregated in group totals

‡ Consultations are the times each disease was diagnosed They are thus overstated to a certain extent by counting each diagnosis made at multiple diagnosis consultations

Tables 11 and 12 give some information on the extent of illness in different age groups in two different studies Table 13 shows morbidity by severity of illness from the Survey of Sickness study done in Britain From Tables 14 and 15 showing consultations by age groups and by place, it is readily seen that an increasing amount

of the general practitioner's time is spent in the care of the aged

The clinical problems posed by age-linked diseases are the everyday problems in the medical practice of the family physician and will become more so as the old age population increases An important contribution that can be made now to the medical care of the aged is to inculcate in the medical student, general practitioner, and specialist the idea that it is socially

TABLE 12*

RATES OF NEW AND RECURRENT ILLNESSES TOGETHER WITH INCAPACITY AND MEDICAL CONSULTATION RATES ARISING FROM ALL SICKNESS NEW AND CONTINUED PER 100 PERSONS INTERVIEWED

	1947	1948	1949	1950	1951
New and recurrent illnesses					
21–64 years	44	40	44	44	57
65 and over	39	39	44	42	55
Incapacity					
21–64 years	161	97	112	115	233
65 and over	255	224	217	212	371
Med cal consulta tion					
21–64 years	49	39	48	43	60
65 and over	73	64	72	68	88

* After Survey of Prevalence of Sickness, March Quarter 1951 *Monthly Bulle n of the Min stry of Health and the Publ c Hea & Laboratory Service* 10 (October 1951) 240

TABLE 13*

PERCENTAGE DISTRIBUTION OF ILLNESSES BY CATEGORY OF SEVERITY (SEXES COMBINED) JULY JUNE 1947–48 AND 1948–49

	Se rious	Mod-erate or M ld	Minor	Ill De-f ned	Total
Aged 16–64 years					
1947–48	2 2	5 4	70 8	21 6	100
1948–49	2 3	6 0	65 1	26 6	100
Aged 65 and over					
1947–48	12 1	4 5	67 6	15 8	100
1948–49	11 4	5 2	63 3	20 1	100

* After W P D Logan, "Illness, Incapacity and Medical Attention among Adults, 1947–49" *Lancet* April 22 1950, p 773

and economically fruitful to treat diseases in the old The factor of age alone ought not to weight a decision against active treatment for the old person The idea that age makes disease incurable is not tenable It is possible to arrest, modify, or even reverse apparently irreversible changes and every tissue should be allowed the chance of becoming restored to as near to normal a functional state as possible Early diagnosis, active treatment, and rehabilitation may not achieve a medical cure, but they can prevent chronic invalidism and loss of personal and economic independence and reduce the demands on community resources

TABLE 14*

CONSULTATIONS BY AGE GROUPS

Age Groups Male and Female	Total Con sultat ons in One Year	Pat ents in Each Group	Average Consulta t ons per Pat ent per Annum
Up to 14 years	24 011	6 712	3 58
15–64 years	66 328	17 957	3 69
65 years and over	14 400	2 696	5 34

* After R C Walsh, "Medical Care of Old People at Home" in *Old Age in the Modern World* (Edinburgh E & S Livingstone 1955) p 80

F Assessment of Type of Medical Care Required by the Aged

It is now generally agreed that hospitalization of the older individual often leads to his physical and mental deterioration The discovery that a great many hospitalized old people suffer from hospitalization rather than illness has introduced a new concept about the kind of service required for the care of the old, and today the cardinal principle in the care of the aged is that, in sickness or in health, old people are better off in the

s

t

h

a ... disoriented in strange surroundings, and it is impossible to give them the

cer mortality, and vigorous therapy should be directed against the tumor consistent *with the requirements of the case irrespective of age.*

MORBIDITY AMONG THE AGED

It is important to know the incidence of disease in the aged in order to plan intelligently for the medical and social services they require. Sheldon's (1948) survey in Wolverhampton showed that 29 per cent of the subjects were receiving medical attention at the time of survey. Hobson and Pemberton (1955), in the Sheffield survey, found that about 47 per cent of the old people were receiving medical attention every 3 months or more often. In the general practitioners' survey in the Netherlands (van Zonneveld and Groen, 1957), 40 per cent of the men and 60 per cent of the women were receiving medical attention regularly at the time of survey. The same proportion had consulted their doctors within 3 months prior to the investigation.

In Britain the Monthly Survey of Sickness conducted by the Ministry of Health (1951–52) reports "ill defined symptoms" the most frequent complaint of persons over 65 years, with rheumatism next. In the fall of 1957 a national survey on morbidity on a random sample of 75,000 families was started in Italy. This study should provide some interesting facts about illnesses and illness rates among the older aged members of these families (Canaperia, personal communication). There is a need for more morbidity studies in the general population to furnish a total picture of the nature and extent of illness among the aged. At the present time almost the only source of information, outside reportable diseases, on the prevalence of illness and disability is hospital records. These do not give a true picture of morbidity from all diseases, including the less serious and non-disabling illnesses, which is a prerequisite for setting up health services that will meet the overall needs of the aging.

Tables 11 and 12 give some information on the extent of illness in different age groups in two different studies. Table 13 shows morbidity by severity of illness from the Survey of Sickness study done in Britain. From Tables 14 and 15, showing consultations by age groups and by place, it is readily seen that an increasing amount

TABLE 11*

PATIENT POPULATION,† ALL DISEASES AND CONDITIONS REQUIRING CONSULTATIONS,‡ IN EIGHT PRACTICES FOR THE PERIOD APRIL, 1951—MARCH, 1952, BY AGE AND SEX

Age Group	Population—All Eight Practices		Consultations—All Practices			
			No		Rate per 100 Practice Population	
	Male	Female	Male	Female	Male	Female
0–14	3,135	3,138	11,862	12,149	353	363
15–44	4,787	6,456	13,741	26,591	268	386
45–64	2,352	3,187	10,093	15,913	399	468
65 and over	1,031	1,488	5,114	9,286	460	582
Not stated	824	967	. .			
All ages	12,129	15,236	40,800	63,939	336	420

* After W. P. D. Logan, *Studies on Medical and Population Subjects* ("General Practitioners' Records," No. 7 [London: H.M. Stationery Office, 1953]), pp. 41 and 85.

† Patients consulting are the numbers consulting for each specified disease and are not aggregated in group totals.

‡ Consultations are the times each disease was diagnosed. They are thus overstated to a certain extent by counting each diagnosis made at "multiple diagnosis" consultations.

to compare needs If the trend toward establishing special geriatric units in general hospitals extends in more countries the need for each kind of accommodation will be more sharply defined In Switzerland it is estimated that 4–5 per cent of persons 60 years and over need care in a home and that there is a need for 2 0 beds per 1000 population for the chronically ill (Pfister, 1951) Roth (1955) reported 25 000 persons over 65 years living in private and public homes for old people in Switzerland where there are 7000 beds for old people in need of nursing care in homes for the chronic sick. Although there are no purely geriatric hospitals in Switzerland eighteen hospitals have special units for the care of the aged and chronic sick In Sweden in the acute hospitals of the Stockholm area on May 12 1953 31 1 per cent of 1101 patients were 60 years and over, reflecting roughly a proportion of six to seven old persons per 1000 population getting hospital care (Berg 1954) The Swedish Hospital Committee in 1943 (Erlandsson 1956) found 3–4 per cent of Sweden's old age population to be suffering from chronic illness and recommended expansion of facilities for chronic illness to cover 3 per cent of the aged population or accommodations for 20 000 persons The Riksdag in 1947 adopted a declaration of principle governing the design and maintenance of communal homes which were to be developed as real homes for normally aging persons and invalids (Swedish Social Welfare Board 1952) Sick old people requiring special care were to be admitted to hospitals or nursing homes dealing with chronic physical or mental disease

Studies of hospital admissions in France show that on the general medical services of one hospital 28 4 per cent of the patients over a 4 year period were over 65 years of age (*Delore* and Arnaud 1956) In 1954–55 35 per cent of hospital admissions to the Hotel Dieu in Paris were more than 60 years of age and occupied 51 3 per cent of the hospital beds 18 per cent of the admissions were more than 70 years of age and occupied 31 8 per cent of the hospital beds The number of beds occupied increased with advancing age (Magdelaine and Pequignot, 1957) Huet (1957), discussing the excessive occupancy of hospital beds by the aged attributes the misuse of the facilities of the hospitals of the public assistance to the lack of appropriate community services which forces the old who are not in need of medical care in hospitals nevertheless to seek admission to them He estimates that for old people depending on public assistance 7500 beds are necessary—5000 for the disabled and 2500 for the fit At present there are only 3500 beds in homes for the aged, forcing old people who cannot be accommodated in homes to seek hospital admission In view of these figures, Delore's (1956*b*) estimate that 20 per cent of hospital beds in France should be reserved for old people does not seem adequate under the existing organization of facilities for the aged

There are at present in Brussels 770 beds available in the geriatric center for old people [illegible]

[illegible] beds will be needed (Clerens, 1956)

There has been an increase in the proportion of persons 65 years and over in the population of the Netherlands from 6 per cent in 1900 to 8 5 per cent in 1957, and it is estimated that by 1980 it will be 11 1 per cent A recent survey on the number [illegible]

[illegible] and 1954 shows an increase in the percentage of old people in the total hospital population during these years In 1924 the percentage of people over 65 years of age in the hospitals was 7 in 1939 the percentage was 10, by 1954 it had increased to 16 The percentage increase of those 65 years and over in the hospital population was greater than the percentage increase for the same age group in the total population—the percentage of persons 65 years and over in the hospital population was 16 per cent in

individual and personal attention possible at home, so that, in addition to the illness for which they were admitted to the hospital, complications develop in the wards Rowntree (1947) estimates that, in England, only 5 per cent of old people need communal care because of increasing feebleness or actual ill health, the other 95 per cent can live on their own or with relatives Moreover, 70–80 per cent of the disabled can be cared for at home if adequate medical, para medical, and social help is available Erlandsson (1956) lists the following conditions as doing better at home with domestic help than in the hospital sequelae of cerebral lesions without progressive paralysis invalidity following fracture of the neck of the femur and amputations psychic changes blindness and bed cases where nothing can be gained from further vigorous treatment or hospitalization

NEED FOR HOSPITAL BEDS AS REVEALED BY SURVEYS

Lord Amulree (1953) of St Pancras Hospital in London estimates the need for beds of the geriatric service of a general hospital to be 0 5–0 75 per 1000 population In England and Wales as a whole just over 1 2 beds per 1000 population have been allocated in the National Health Service (1957) hospitals as giving reasonable hospital service with no undue strain for the treatment of chronic sick patients other than the mentally ill and mentally defective For England and Wales in 1951 the ratio of chronic beds per 1000 general population was 1 35 To achieve this ratio 12 per cent of hospital beds were reserved for the chronically ill Amulree stresses especially the proper utilization of the hospital bed—"the right patient in the right bed"—as a means of increasing availability of hospital accommodation to the sick population where hospitalization is really needed for active treatment

At the Seventh International Hospital Congress Tunbridge (1951) stated that the Nuffield survey in England revealed a need for 2 5 beds per 1000 population for the chronically ill and that more than 60 per cent of the beds in hospitals for the chronic sick were occupied by patients over 65 years of age

The reports on accommodation needed for the care of the aged chronic sick do not always distinguish between the need for facilities for active treatment in hospital or nursing care in nursing or "old age" homes and it is therefore, difficult

TABLE 15*

CONSULTATIONS BY PLACE IN EIGHT PRACTICES APRIL 1951—MARCH 1952
(Rate per 100 Practice Population)

Age Group	All Eight Practices		Surgery				Home Visits				Other Consultations			
			Male		Female		Male		Female		Male		Female	
	Male	Female	No	Rate	No	Rate	No	Rate	No	Rate	No	Rate	No	Rate
0–14	3 135	3 139	7 123	211 9	7 223	215 6	4 136	123 0	4 287	128 0	603	17 9	639	19 1
15–44	4 797	6 456	11 256	219 3	20 200	293 2	1 866	36 4	5 341	77 5	619	12 1	1 010	15 2
45–64	2 352	3 187	7 375	292 0	11 154	328 1	2 100	83 1	3 785	111 3	608	24 1	9 4	25 6
65 and over	1 031	1 488	3 085	277 7	3 799	238 0	1 714	154 3	4 660	292 0	315	28 4	92	51 8
Not stated	824	967												
All ages	12 129	15 236	28 839	23[illegible] 7	42 376	279 1	9 816	80 9	18 073	118 6	2 145	17 7	3 490	21 9

* After W P D Logan, *Studies on Medical and Population Subjects* ("General Practitioners Records," No 7 [London HM Stationery Office 1953]) based on material taken from p. 119

is in Britain and has been developed as part of the provision of the National Health Service (1957) Different areas in Britain have pioneered in services to the aged For example a laundry service was first started in Bristol in 1951 with money from the National Corporation for the Care of Old People (Walsh 1955) In Oxford a day hospital was created to care for burden some cases and by providing relief to ex hausted families prevented a breaking up of the family (Townsend 1955) Buckinghamshire in the Oxford Regional Hospital Board area pioneered in the use of a con sultant in geriatrics to serve both hospital and local authority This resulted in the better use of existing beds and therefore of hospital facilities

A survey of services available to the chronic sick and elderly in 1954–55 stud ied hospital and specialist services provided for old people and the chronic sick (other than the mentally ill or defective) and their relation to the services provided by local authorities in both their health and their welfare capacities (Boucher 1957) The National Health Service provides for hospital service preventive health service through the local health authority and general practitioner service which en ables everyone to have a family doctor The National Assistance Act of 1948 ex tended the local health authority service to provide care to the sick at home

Responsibility for the care of the chron ic sick and old is therefore shared by hos pital local authority and general practi tioner and their first aim is to provide ade quate care and treatment of old people in their homes for as long as possible Domi ciliary services cost less than residential care or hospital care and *in the long* run are more economical However to be com pletely effective home care requires full development and integration of preventive domiciliary and outpatient services even when they are administratively and finan cially independent

The best practices revealed by the sur vey were brought to the attention of those responsible for the development of services to the aged in Britain for general imple mentation and are summarized here

1 *Home care* is provided by general practitioners with the co-operation of the local health authority It takes care of all sick who do not need, or cannot benefit by, hospitalization

2 *Hospital care* is available for the acute sick and for the chronic sick in need of active treatment Although medical care is furnished by the hospital staff, total med ical care requires the co-operation of the general practitioner and local health au thority personnel In Britain the trend has been to organize geriatric services attached to general hospitals as an integral part of the hospital The diagnostic and consulta tion services of the hospital are available to geriatric patients, and all other supportive facilities are created to insure continuity of care of the elderly patient at home in hospital and after hospital discharge Ideally there should be no more than 100–150 beds in a geriatric unit (Delore 1955 Warren 1956a) Smaller centers located nearer the homes of the old people are be ing developed in relation to these larger centers to make it easier for the elderly hos pital patient to retain contact with family and home The Geriatric Service is not used as a service for incurables but tem porary admissions or regular readmissions of suitable patients are permitted where hospital accommodation exists Temporary hospitalization of these burdensome cases relieves the strain on families and offers an opportunity for a medical checkup of the chronic patient The standard for hospital beds excluding the mentally ill and defec tive—1 2 per 1000 population—will vary depending on local factors, but in areas where age distribution of population is nor mal and where effective ancillary services exist it will provide a reasonable hospital service

It is not the responsibility of the hospi tal authority to give all the medical or nursing care needed by an old person how ever minor the illness or however short the

1954, while the percentage in the Netherlands was 8 2 per cent However, there is no great difference in the percentage by 5 year age groups when the distribution of aged patients in the hospitals is compared to the distribution of the total aged population of the country by the same age groups This would seem to indicate that becoming older does not necessarily mean a greater likelihood of being admitted to the hospital (Bronts and van Zonneveld, 1957) The Groningen survey (van Zonneveld, 1954) had concluded that, considering no other circumstance but the physical and mental state of the old person, the needs per 1000 population older than 64 years are 4 3 beds in general hospitals, 34 beds in nursing homes for the chronically ill, and 153 beds in old age homes for the frail who do not need special nursing care In addition, more beds are needed for rehabilitation Home help is needed for 3 7 per cent of the old people The survey found that 43 per cent of the old people were able to live independently These figures do not differ from those calculated for the whole aged population of the Netherlands More recently, van Zonneveld (1957) reported that 3 7 per cent of the old people of Groningen need immediate admission to old age homes and that 2 per cent need to be admitted to a nursing home

The facts brought out by these figures illustrate the disproportionate use of hospital facilities that might occur when more suitable services and accommodations are lacking and indicate the estimated need for hospital and nursing care for the aged in several countries

DURATION OF HOSPITAL STAY

Lord Amulree (1953) states that from one fourth to one third of the admissions to geriatric units will die in the first month for the others the average length of hospital stay will be about the same as for the younger age groups At St Pancras the length of hospital stay on the Geriatric Service was 42 days, as against 35 days for patients on the medical, chest, and skin services Of 894 patients admitted to the Geriatric Unit, only 77 remained longer than 6 months The average duration of hospital stay at the Hôtel Dieu, Paris (Magdelaine and Pequignot, 1957), among all patients 70 years and over was 54 93 days, as against 19 23 days among all patients 50 years and less The mean duration of stay on the Geriatric Service of the Hospital in Sabbatsberg, Sweden was 1 year and 2 months, which Erlandsson (1956) considers too long for effective utilization of hospital beds On the Geriatric Unit of the Ulleval Hospital in Oslo, Norway (Gaustad, 1956), only 5 per cent of 739 cases admitted in 1953 were still there at the end of April, 1954 In the twenty one hospitals investigated in the Netherlands the median length of hospital stay of patients 65 years and over was 43 days in 1954, about two to three times longer than the mean length of stay of patients under 65 years of age

The need for hospital beds and the duration of hospital stay will be reduced by the development of geriatric units for active diagnosis and treatment in connection with the general hospitals and by the creation of ancillary services and facilities outside the hospital for the care of the disabled, infirm, and chronic sick

II PROGRAMS FOR PROVIDING MEDICAL CARE FOR OLD PEOPLE

A Medical Care for the Aged in Britain

This section attempts to give an idea of what several European countries are doing to provide medical care for their old age population Health programs for the care of old people stress preventive measures and rehabilitation to prevent illness, infirmity and disability and to keep the old at home where they do better living independent lives for as long as possible Planning along these lines is socially and economically sound The most extensively organized program for health and medical care in western Europe at the present time

contacts provided by the day hospital relieve the monotony and isolation of the lives of lonely, elderly chronics and improve their mental attitude These hospitals have been found feasible for patients with some mental impairment, although this requires liaison with the mental hospital and co-operation with an ambulance service By sharing in the care of a difficult sick aged member, they have rendered an important service to families

6 *Residential care* is provided by the Welfare Authority Residential care is provided for (1) active elderly people in need of such care, (2) the otherwise active resident during minor illnesses which may involve a short period in bed, (3) the infirm including senile who may need help in dressing toilet etc or who may need to live on the ground floor because of inability to manage stairs or who may spend part of the day (or longer periods during bad weather) in bed and (4) the elderly who have to take to bed and are not expected to live more than a few weeks and who cannot benefit from treatment or nursing care beyond what can be given at home and whose removal to a hospital, away from familiar surroundings and attendants would be felt to be inhuman

The small welfare homes accommodating twenty to forty residents are for those aged who can take care of the personal necessities of living and are under the direction of a warden or matron Care is given by attendants assisted or advised by the visiting nurse In larger homes there is a superintendent and/or matron in charge, and care is given by a small staff with nursing qualifications or experience They admit the more physically or mentally infirm and disabled who need greater care and supervision Hygiene of the homes is supervised by the medical staff or medical officer of health Residents are free to nominate their own doctor, and, in addition, a local practitioner may make one or more routine visits a week

The welfare authority does not have to provide prolonged nursing care to the bedfast, except for those in the last stages of their lives It is felt that the concentration of disabled and bedfast patients in "infirmary wards" attached to larger homes is inadvisable

Old people fluctuate between infirmity and sickness, and arrangements should facilitate their temporary or permanent admission from welfare homes to hospital when health deteriorates or, conversely, the transfer from hospital to welfare homes when health improves and there are no relatives or friends to go to The situation where a hospital patient is medically fit but cannot be transferred to a welfare home because of an apparent lack of accommodation, while at the same time residents in suitable welfare homes are waiting admission to hospital can be avoided by the appointment of a consultant geriatric physician working with the regional hospital board and the local authority and having responsibility for, as well as access to, all accommodations Such an arrangement has proved successful in Buckinghamshire and the Oxford Regional Hospital Board area

7 *Home medical service* has been of great value in helping to keep sick old people out of institutions and hospitals The doctor is the team leader in this multidisciplinary approach in caring for the old at home, but, to be effective, it requires the co-operation of the statutory and voluntary organizations, doctors, nurses, social workers, and other paramedical staff

A wide range of organizations and interested individuals, even in war years, co-operated in the development of the highly successful schemes for home medical service to be found in Britain today The National Old People's Welfare Committee was formed in 1940 to study the needs of old people, to encourage and promote measures for their well being, and to co-ordinate the services provided them The committee is independent of statutory authorities, although it receives recognition and support from them, and plays an important role in the care of the aged

stay in bed, nor does the hospital have to admit all those who need nursing care because they are entering upon the last stages of their lives

Patients with acute illnesses or exacerbations of chronic conditions are admitted to the hospitals as emergencies Other patients upon application for admission by the general practitioner are placed on a waiting list The physician in charge of the Geriatric Service, alone or with the social worker from the hospital or local authority, and with the agreement of the general practitioner, who may wish to be present, visits the patient at home to determine the medical and social needs and to assign priority for admission to the hospital The general practitioner is always kept fully informed of the findings and status of his patient Alternatively, patients may be seen in the Geriatric Outpatient Department by the Geriatric Service physician When the latter cannot visit the patient at home, the social worker makes a home visit to assess the social conditions before placing the patient on the waiting list, and there is a standing arrangement for regular review of the waiting list

Either health visitor, social worker, or other officer of the local health authority makes periodic visits to those on the waiting list to reassess need for admission The health visitor, who may be attached part time to the Geriatric Service of the hospital maintains liaison between the Geriatric Service and general practitioner and sees that the patients on the waiting list get all the home help possible while awaiting hospital treatment The functions of the health visitor, who is a trained nurse and midwife with sociological experience were widely extended by the National Health Service Act, and she plays an important role in the health program for the aged

After discharge from hospital continuity of care is insured by notifying the general practitioner and if the patient consents, the medical officer of health The hospital and local authority service co operate in providing continuing care following hospitalization The local authorities, in their health capacity, provide home nursing domestic help, health visitors, and other domiciliary services, in their welfare capacity they provide residential accommodation and certain domiciliary services that come under the National Assistance Act

Other facilities that extend hospital care outside hospital premises and permit a greater use of hospital beds are

3 *Convalescent homes,* or "halfway houses," have been useful in freeing expensive hospital accommodation and in continuing hospital care, preferably carried on by the same personnel, for the final stages of clinical rehabilitation and social readjustment These homes or annexes for short stay are used for patients who have finished active treatment but for various reasons cannot return home immediately and are never used for direct admission of a new patient

4 *Long stay accommodation* for patients who cannot benefit from active treatment but who need a higher standard of nursing than they can get at home or in a local authority provision has also proved useful Patients are first admitted to the Acute Geriatric Service for assessment before going to long stay centers These homes are integral parts of the Geriatric Service sharing its personnel and patients remain under the supervision of the physician of the main geriatric center They admit patients confined to bed and unable to return home patients who show mental symptoms that make it impossible for them to be with others in common rooms and patients who can get only to a wheel chair and who cannot go to a welfare home

5 *Day hospitals* have been useful in relieving hospital and home in the care of the chronic sick Patients may be discharged from hospitals earlier than usual to continue treatment there, or treatment can be started in day hospitals while awaiting admission to hospital Physiotherapy and occupational therapy are available and rehabilitation for hemiplegics can be continued, individually or in groups The social

contacts provided by the day hospital relieve the monotony and isolation of the lives of lonely, elderly chronics and improve their mental attitude These hospitals have been found feasible for patients with some mental impairment although this requires liaison with the mental hospital and co-operation with an ambulance service By sharing in the care of a difficult sick aged member, they have rendered an important service to families

6 *Residential care* is provided by the Welfare Authority Residential care is provided for (1) active elderly people in need of such care, (2) the otherwise active resident during minor illnesses which may involve a short period in bed, (3) the infirm, including senile, who may need help in dressing toilet, etc or who may need to live on the ground floor because of inability to manage stairs or who may spend part of the day (or longer periods during bad weather) in bed and (4) the elderly who have to take to bed and are not expected to live more than a few weeks and who cannot benefit from treatment or nursing care beyond what can be given at home and whose removal to a hospital, away from familiar surroundings and attendants would be felt to be inhuman

The small welfare homes accommodating twenty to forty residents are for those aged who can take care of the personal necessities of living and are under the direction of a warden or matron Care is given b... atte..d

...g qualifications or experience They admit the more physically or mentally infirm and disabled who need greater care and supervision Hygiene of the homes is supervised by the medical staff or medical officer of health Residents are free to nominate their own doctor, and, in addition, a local practitioner may make one or more routine visits a week

The welfare authority does not have to provide prolonged nursing care to the bedfast, except for those in the last stages of their lives It is felt that the concentration of disabled and bedfast patients in "infirmary wards" attached to larger homes is inadvisable

Old people fluctuate between infirmity and sickness, and arrangements should facilitate their temporary or permanent admission from welfare homes to hospital when health deteriorates or, conversely, the transfer from hospital to welfare homes when health improves and there are no relatives or friends to go to The situation where a hospital patient is medically fit but cannot be transferred to a welfare home because of an apparent lack of accommodation, while at the same time residents in suitable welfare homes are waiting admission to hospital can be avoided by the appointment of a consultant geriatric physician working with the regional hospital board and the local authority and hav...

...g ... Hospital Board area

7 *Home medical service* has been of great value in helping to keep sick old people out of institutions and hospitals The doctor is the team leader in this multidisciplinary approach in caring for the old at home, but, to be effective, it requires the co-operation of the statutory and voluntary organizations, doctors, nurses, social workers and other paramedical staff

A wide range of organizations and interested individuals, even in war years, co operated in the development of the highly successful schemes for home medical service to be found in Britain today The National Old People's Welfare Committee was formed in 1940 to study the needs of old people to encourage and promote measures for their well being and to co-ordinate the services provided them The committee is independent of statutory authorities, although it receives recognition and support from them, and plays an important role in the care of the aged

Domiciliary service requires the co operation of a cohort of social workers, ministers, relatives, and friends to assure an efficient, integrated scheme that will assist old people in remaining in their homes with comfort to themselves and without undue strain on their families

Loneliness is a generally recognized factor in senile decay A "visiting service developed under the Welfare Department has done a great deal to help old people living alone It is one of the main services rendered by local voluntary committees and brings to the old the community services available to them Next to being visited the three most common needs of old people are help with meals laundry, and chiropody Civic restaurants offer cheap hot balanced meals to pensioners in arrangement with owning authority, welfare authority, and voluntary organization "Meals on wheels' for the housebound are organized by the Women s Voluntary Society British Red Cross Society, or Salvation Army, and a hot meal is brought to the housebound at midday once twice, or six times weekly Laundry is often the last straw that forces families to seek institutional care for their aged especially in continents Laundry help is provided through voluntary organizations sometimes collaborating with municipal authorities In some boroughs of London linen is collected in containers three times weekly and returned quickly Linen and night clothes kept by the district nurse are available through a lending service Automatic washing machines with special facilities for drying and ironing are set up in accessible places so that old people or their families can for a small charge do their own laundry Chiropody is not yet included in the services provided by the National Health Service but is of great value in keeping old people ambulant and independent Voluntary effort with the co operation of the local chiropodists and some help from the local authority, has in some areas provided cheap or free service to pensioners Service is also given through clinics and for those who cannot get out a home service is available (Evans, 1955, Walsh 1955)

Holidays at seaside for those who would benefit from them are arranged by the Old People's Welfare Committee Some five thousand social clubs in the country—and more are envisioned—have also been developed by the Old People s Welfare Committee with the co-operation of doctors as a means of providing many services that help to keep the old out of hospitals

More and more of the general practitioner's time is being spent in the care of aged patients The average number of consultations per patient per annum for the 65 and over age group is greater than for any other age group and as the population ages the number of older patients in the general practitioner s practice will increase Logan (1953) reports the study of consultations by age groups in eight representative practices in England and finds that in the 65 and over group the average number of consultations per patient per annum is 5 34 as compared to 3 69 for the 15 64 year group and 3 58 for the group under 15 years (Table 14) The Ministry of Health s (1951–52) surveys on the prevalence of sickness also reveal a greater number of consultations among persons 65 years and over than in younger age groups (Table 12) Old people should be provided with a family doctor who can see them at home and a geriatric physician should be available for consultation at the patient s home or at the clinic to assess the need for admission to the Geriatric Service of the general hospital or other accommodation

Nursing help of various kinds such as simple dressings bed care and injections can be provided at home and a state-registered or state enrolled nurse or male or female practical nurse may be employed to give this service Health visitors (who in Britain are public health nurses and act as counselors and health educators but are not responsible for practical nursing service) see that the old get the services they need (Lamont 1953) Night attendants have proved helpful in giving night care

and affording relief to families from the burden of steady care

Some of the medical aids that help the old person at home to preserve his independence are eyeglasses, dentures, hearing aids, trusses and surgical appliances, multi leg walking sticks for the disabled, eating utensils with built up handles combination knife and fork to permit hemiplegics to eat unassisted elastic shoelaces and long shoe horn to aid arthritics, and long handled combs (Warren, 1955)

Mechanical aids and safety devices can be provided to help the old person in independent living and to protect him in his environment (Walsh, 1955) Rails along staircases or ramps over staircases, handles by stairs and lavatory, adaptations of kitchen equipment, shelves, etc, to overcome disabilities from arthritis, hemiplegia and other defects and loan of bedpans commodes crutches, wheel chairs, and special beds (from local authority or British Red Cross Society) support the old person and allow him to manage for himself All safety appliances and measures, *such as* non skid mats and polish fire guards and adequate lighting of dark corners should be employed to protect the aged from injury

Transport facilities and ambulance service must be available to enable the old person to utilize the medical and social resources of the community and to benefit from home medical care

8 *Outpatient services* for the ambulatory and non resident sick make it possible for the elderly to remain home and also benefit from medical care Besides functioning as a *consultation* service for general practitioners the outpatient department classifies the sick and finds those cases needing social welfare services ho...

... y services It treats cases amenable to therapy on an outpatient basis and follows patients who after discharge from hospital still require treatment at home or in welfare homes By continuing care after hospital discharge, disability can be prevented and hospital readmission avoided It also offers a means of early therapy which may arrest deterioration and eliminate need for hospital admission Attendance at geriatric clinics in Great Britain increased from 6988 in 1950 to 18 401 in 1955 (Great Britain, National Health Service, 1957) The outpatient department can be used for patients awaiting admission to hospital, the general practitioner still continuing surveillance of his patient. An efficient appointment system to reduce waiting time and the co operation of the local authority in running an ambulance service are requisites for an effective outpatient service

Physiotherapy and occupational therapy services can be provided through clubs, day hospitals, and outpatient departments and permit the discharge of patients from hospitals earlier than would otherwise be possible Treatment, especially rehabilitation of hemiplegics on an individual or group basis, can be continued in these centers Physiotherapy and occupational therapy are important measures in relieving pain, in preventing or delaying deterioration, and in helping to maintain or restore independence of the old person in his home or in an institution

B Medical Care in Sweden

Basically the same trends in the development of medical care for the aged are seen in Swed... e num... n 1950 ... of the whole population, in 1955 the numbers had ...

... in 1970 the number of persons 65 years or older will be 1,020 000, or 13 per cent of the entire population In spite of this increase in the so-called non productive, dependent maturates of the population, the level of life has improved in Sweden Not only have better food, better

housing, and better medical care made it possible for the aged to look after themselves but the tradition of family and neighborly help, respect for personal liberty, and sense of community responsibility for the individual have always helped the majority of old people to spend their old age in their own homes Here the care of the aged is the responsibility of the municipal authority, and the community tries primarily to make it possible for the aged to manage for themselves in their own surroundings so that the majority of the aged do live outside institutions A pension system whereby everyone from the age of 67, regardless of economic class, receives a pension makes it possible for old people to get along without other pecuniary assistance However, where need can be shown, the local authorities, subsidized by the state, may grant a further amount for rent

The increasing number of aged creates an ever increasing demand upon the resources of social health care It is estimated that about 20 per cent of the aged older than 65 years need permanent care of some sort (Engel, personal communication) Hospitals and nursing homes are used where permanent care or treatment are needed Municipal homes for the aged are meant only for those who, though not actually sick, cannot manage for themselves alone or even with occasional domestic help About 4 5 per cent of the aged over 70 years are cared for in homes for the aged The Riksdag in 1947 removed the homes for the aged from the Public Assistance Authority and designated them to be used as real homes for normally aging persons and invalids in need of permanent care Sick old persons and others requiring special care were to be admitted to hospitals or nursing homes for chronic illnesses or mental disease However lack of facilities for the care of the chronic and mentally ill has made it necessary for the homes for the aged to continue to shelter some of these cases

Homes for the aged now come under the Social Aid Act and are the responsibility of the Royal Social Board Subventions from the state to the municipalities has furthered a program of new building and modernization of old institutions The homes for the aged are open institutions where the aged may live if he wants and needs to do so They are attractive abodes where the old person may have his own furniture and personal belongings if he wishes and for which he pays a fee predetermined by the municipalities In 1954 there were about 1350 homes for the aged with 37,000 beds Although building and modernization of old buildings are creating additional beds, the relative number of beds is decreasing, owing to the increase in the number of old people In 1950 excluding homes for the chronic and mentally sick, there were 75 beds per 1000 persons over 70 years of age as against 99 beds per 1000 persons over 70 years in 1938 However as other means of treatment are enlarged to meet the specific medical needs of the old, the prevailing number of beds in these homes seems sufficient

In Sweden special home help for old people was first started in 1950 with the pioneering work of the Red Cross at Upsala and has rendered a valuable service in making it possible for many old people to remain in their own homes (Nordstrom 1956) Home help service now covers the whole country although it is further advanced in some parts such as Stockholm Goteborg and Malmo The need for additional beds in homes for the aged has been lessened by this service It has moreover provided the kind of care that old people prefer in a manner that serves their interest best at a lower cost to the community The home-help services are organized and financed by different agencies—for the old by the local authority or the Red Cross for invalids or chronic sick (including usually a number of aged) by the provincial council responsible for medical care, for families by the local authorities Home help services are available to all people regardless of economic status, but, where the individual or family is able to pay for the

service he does so, not directly to the helper but to the agency responsible for running the service

Home helpers are housewives or mature women with free time to give to this service They clean wash up, buy and prepare food or help with dressing personal hygiene walks They get some general instruction from the agency organizer or district nurse but receive no special training Those who work among the sick aged are given a short course of 50–100 hours in sick care through the Red Cross On the other hand training of matrons for the homes for the aged is organized by the Swedish Social Care Association at state expense for about 3 years the greater part of the time being spent in institutions

In 1952 the minister of social affairs appointed a committee to survey the problem of health care for the aged The committee —

sions reached—namely to support and strengthen measures in the field of old age pension housing and domestic help to allow the old to live independently, to increase the number of institutions for old people with chronic illnesses and to reserve the homes for aged for those who are not actually sick but who are in need of constant care and to intensify research in aging

The Swedish Parliament passed a law in 1951 which established in principle the right of every citizen to receive free medical care under a national insurance plan but economic developments within the country have not permitted its full realization

Medical care service for the old is at the debut of organization in Sweden and the formula best suited to its needs is still a matter of discussion At the present time medical care is the chief responsibility of the provincial councils or governments although the top authority and supervision over the care of the sick belong to the State or Royal Medical Board However, the state has actually taken over only a small part of the care of the physically ill, practically limited to the university teaching hospitals The state does furnish the greater part of the care of the mentally ill Hospitals are the responsibility of provincial councils and provide hospital care for old people The Royal Medical Board is responsible for the care of the mentally ill old person The Royal Social Board is responsible for homes for the aged and medical care of old people Since the Royal Social Board has no full time doctors on its staff difficulty and delay sometimes arise in distributing the medical cases falling under its jurisdiction The old person, presenting symptoms of various chronic illnesses and disabilities often suffers from the del…

Sweden, although a visiting nurse service is available

In the summer of 1950 Erlandsson (1956) started a geriatric service in the hospital at Sabbatsberg, Stockholm where a home for the aged has existed since 1752 (Hilleboe, 1955) Projects to establish geriatric medical services in connection with hospitals, ambulatory medical care, and centers for preventive treatment and to increase and make more effective home help are under way

Although there is a difference of opinion as to who should sponsor geriatric units and consequently, as to whether they should be attached to hospitals under the county or provincial council or to homes for the aged under the municipal authority there is general agreement on the urgent need to expand the number of beds in suitable hospital facilities for sick old people (Kindstrand 1947, Birch Lindgren 1956) Erlandsson estimates the need for 20 000 beds, covering 3 per cent of the aged population, to take care of the chronically ill and to be divided (although allocation is difficult) between the geriatric service and infirmaries or rest homes for sick old people

In Sweden serious thought and careful planning are going into creating a scheme of old age maintenance, adapting the results of gerontological research and the experience of others, to meet the problem now and in the future Erlandsson distinguishes three groups of old people who require different kinds of care The first comprises aged persons in good health or persons who are infirm and best cared for in their own homes or in homes for the aged In the second group belong aged persons who are acutely ill and who should be given medical care at home or in the hospital The third is a group composed of aged persons with chronic illnesses or persons who are continuously ill and cannot be cared for at home and for whom long term care in a geriatric unit attached to a general hospital will be necessary Whether the geriatric unit is part of a large hospital or a small unit close to the patients' homes, it should be equipped with all the facilities for diagnosis, treatment, and rehabilitation and should have easy access to the various specialty consultations and services that might be required In addition, the geriatric unit should offer an opportunity for education of the medical and nursing personnel in the care of the aged and should encourage and carry out research in the problems of geriatry

Pedicure, hearing tests and the provision of free hearing aids, the loan of wheel chairs and other hospital equipment to the patient at home through the Red Cross, and laundry service have helped the elderly to remain at home A "meal on wheels" service organized by the Red Cross, restaurants, or homes for the aged delivers daily in some communities to old people living at home

C *Medical Care in France*

In France the problem of the care of the aged is serious, since this country has, along with Belgium, the highest proportion of old people in its population in western Europe The proportion of persons over 65 years in France in 1900 was 8 4 per cent, in 1950 it was 11 4 per cent, and it is predicted that by 1980 the proportion of persons over 60 years in the population will be 18 5 per cent (Daric, 1948, 1956) The greatest cost in care of the aged is the cost of caring for the sick and disabled At present, the care of the aged is still primarily the responsibility of families Few specialized services have been developed in the community Although there are homes for the aged, they have not enough accommodations, and they do not give the aged infirm and chronic sick the medical care they need An inquiry into the status of old people in the north of France revealed an over all insufficiency in all types of services for the aged, including housing and hospitalization (Gosset, 1953, Covalt 1956) Public hospitals furnish medical services on an outpatient basis, and some have day centers where old people can enjoy warm food and companionship Voluntary agencies, frequently under religious auspices, provide some services to old people, and on National Old Peoples Day funds which go to pay for housekeeping help, nursing, meals, and other services are collected by voluntary society agencies Old age assistance benefits are low, and as yet there are few special housing facilities for the aged Following the war, unstable economic conditions and inflation, low wages, the increasing number of women working outside the home who could no longer care for an aged parent, and the weakening of filial ties have all contributed to the plight of the old person in France

Programs for the aged must be geared to the economy of the country One of the plans for the medical care of the aged presented by Huet to the General Assembly of the Advisers of Health at Dijon in 1955 recommends the organization of health care at local levels and suggests establishing in each commune a municipal bureau of social welfare (Wibaux and Huet, 1956) These bureaus of social welfare would maintain contact with the old in their homes and with geriatric services attached to general

hospitals and could assign cases to hospitals for medical care The geriatric hospitals would have attached to them convalescent homes, or "halfway houses," where patients could be sent before returning home, and which could be used as a base for sending patients to summer vacation homes or to give temporary lodging during cold weather They are envisioned also as having a rehabilitation center to train patients socially and professionally, so that they can return to live in their homes and perhaps even to do some work later on Study and evaluation of patients for eventual retraining for possible work later on should be done in the geriatric hospital with the aid of an inspector of work and a social assistant The plan also provides special accommodation to which the geriatric hospitals can send patients after discharge—such as homes for the retired old, homes for the chronically ill, disabled, and bedridden and homes for senile dements, as well as follow up facilities for continuing medical supervision These facilities would enable the geriatric hospital to make the optimum use of its beds for the active treatment of the sick old person

The scheme stresses particularly the organization of home care Domestic help, ancillary services and outpatient services should be developed to keep the old out of hospitals and homes for the aged Providing a midday meal in a restaurant and at home in the evenings and creating clubs and recreational facilities, especially in towns where life is more complex and the old person may be more isolated from [illegible]

[illegible] beds is visualized as being attached to a regional hospital, under the control of the regional geriatry service, and having two medical and one surgical services along with complete up-to-date facilities for diagnosis, treatment, and research It should be staffed by specially trained medical personnel and social assistants and have a small school of nurses attached to it

D Medical Care in the Netherlands

The care of the aged in the Netherlands is regarded as the concern of society as a whole, and several studies of the aged population have already been mentioned In 1949 a national committee for old people's care was formed by the Netherlands Association for Social Work and the Netherlands Association for Gerontology to study and correlate information on the problems and needs of old people

Investigations of rural and urban communities have shown a need for old age homes and nursing homes for the aged Some provision for the care of old people has existed for a long time in the Netherlands Since the thirteenth century the church has maintained *hofjes*, or old age homes, some of which have been modernized and are still in use In Zutphen, over a century ago, homes where the old were housed, fed, and clothed were established by rich merchants and landowners, and in Amsterdam one of these homes has been in existence since 1610 Many of these accommodations are small cottages in attractive settings, and nursing care is sometimes provided for the sick aged In the latter part of the eighteenth century, homes for the old were built by the municipal authorities, and today a variety of establishments supported by church, municipal, or voluntary agencies cares for the aged, including invalids and the chronically ill Some of the larger homes may have modest hospital facilities, and occasionally the smaller homes may have an infirmary Separate facilities are provided for cases of senile dementia (Watkins, 1951)

There are no country wide figures available on accommodations for old people or for the aged chronic sick A survey of 812 non private homes conducted in February, 1950, showed that 29,563 persons 65 years or older were housed in these homes Of these old people, 8.3 per cent were per-

manently bedridden, 28 7 per cent were more or less invalided, and the remaining 63 per cent were still capable of looking after themselves Private homes do not come under statutory regulations, and statistics on them can be obtained only where regulations exist However, the tendency is to bring these homes under governmental control, and now in several large cities and in two provinces regulations do exist so that the government will be able to exercise some control and establish requirements which should be met by the nursing homes In The Hague, in January, 1958, there were 125 nursing homes for a total of 3758 sick, disabled, and incapacitated persons 60 years of age and over Five of these homes are administered by the local government and care for 995 persons, 32 are church institutions and care for 1652 persons, and 88 are privately run homes caring for 1111 persons Of the total number of aged, 1282 (34 1 per cent) were permanently bedridden, 1770 (47 1 per cent) were partially bedridden, and 706 (18 8 per cent) were ambulatory The treatment given in practically all these homes is confined to simple care and nursing Although the sick funds of the national health insurance are gradually extending their coverage, they do not as yet provide for care in nursing homes (Mundendam, personal communication)

In 1953 the Federation of Nursing Homes for the Chronic Sick, which aims at a regular control of nursing homes and a state controlled training of personnel, was founded The federation receives a subsidy from the central government, and about 45 homes with a total of 2000 beds are members A Roman Catholic organization of nursing homes has been established recently

Since the middle 1920's housing developments have begun to make provisions for the aged, either in small units in large projects, which keep the old person near the family, or in dwellings designed particularly to meet the special needs of old people and where nursing care may be given to the sick in his room or in an infirmary In the new architectural development of building a town within a town in a circular plan, a nursing home or hospital toward which the elderly gravitates as he comes to need more and more sick care is placed in the center of the community

The national health insurance in the Netherlands started with sick funds to provide general practitioner's service and drugs and are gradually extending their provisions All persons below a certain income level (6900 florins per year), or four fifths of the population of the country, are covered by the sick fund and are registered with a general practitioner who gives the first medical care (van Zonneveld and Groen 1957) Many agencies co-operate to care for the aged, and much social work is being done among old people The social workers have no special training in the problems of the aged but it is felt that some training is desirable and should be provided The village nurse and private organizations give home nursing and help with shopping The various Cross societies participate actively in providing home help and in eight towns the Union of Women Volunteers has organized "meals on wheels" and "friendly visiting" In Zutphen the Union of Women Volunteers and the Cross Society help old people with their personal hygiene, saving on the use of nursing time for this service Much mutual aid is also given among the old to one another (Gijsbers, 1956)

At the present time there is no national plan for providing special medical care for the aged All sick persons are looked after by general practitioners, and the elderly sick are accommodated in the available community hospital facilities There are no geriatric departments or other special provisions for aged people, and the number of chronic sick aged people in hospitals is comparatively small Hornstra, investigating the need for nursing home care on the Isle of Schouwen Duiveland in 1953, estimated that 2 per cent of the people over 65 years of age needed care in nursing

homes Schreuder, in the agricultural region of southwestern Frisia, found 2·3–4·2 per cent of the old required accommodation in nursing homes Among the 3000 old people in the Groningen survey, 3·7 per cent needed immediate admission to old age homes and 2 per cent to nursing homes In Rotterdam an inquiry among 5800 old people revealed that 5·4 per cent [illegible]

need care in nursing homes they are unwilling to leave their homes to enter communal homes even when the latter are better for them sociomedically

E Medical Care in Belgium

Of all the countries of western Europe, Belgium has the highest *proportion of old* persons in her population and on the basis of the census of 1947 it is estimated that in 1977 the [illegible]

aged well the infirm *and the chronically* ill are different and that a *different type* of service will be *required* for each group The community is not concerned with those in favorable material circumstances Belgium has a tradition of sick care and homes *for* the aged based on charity, and public *or private* hospices have always sheltered the *indigent In 1925 a* commission for public assistance was *established* in each commune to provide welfare assistance, medical *service at home* drugs and hospital care to the *indigent* and under this program of assistance the aged received help at home in money or in kind and care or hospitalization in case of illness Those needing special care because of the infirmities of age *were placed* in special institutions or hospices *provided* by the commission or by *private* and religious organizations

The hospices did not make congenial homes for the aged and the limitations and undesirability of this type of care were recognized In 1949 a memorandum from the Ministry of Public Health and the Family called for the renovation and modernization of archaic institutions into pleasant, comfortable homes where old people would find a more cheerful and homelike atmosphere A subsidy of 60 per cent was offered to encourage this work, and under this stimulus 38 homes were modernized, and 35 new homes were constructed

In 1955 in Belgium there were 548 institutions with a total of 30,948 beds for the old, divided among 236 private institutions having 13,133 beds and 312 welfare homes with 17,815 beds In *addition, there* were 83 religious communities with 972 homes, and other special groups, such as the sailors and displaced persons, also have their own homes for the aged

The buildings of privately run homes are *also being modernized* to provide attractive, comfortable *surroundings* for the aged Residents in homes are admitted at *full* or half rate, or without charge, without any distinction in the accommodation accorded *the individual*, the Commission of Public Assistance being *responsible for the* amount the individual is unable *to pay Pensioners pay for* their accommodation from *their pensions* but are allowed to retain a third for personal use, and pocket money *is given to the* indigent A medical examination is done on admission, and provision is made for periodic medical examination of all residents

A program of building of homes especially designed *for the comfort* and convenience *of* old people has been started. In the *new* buildings single rooms and apartments *for married* couples have been built in pavilions of 30–50 beds in pleasant *surroundings* They are self contained and equipped with amenities that will aid the aged to live independently in comfort and with facilities for recreation and with an infirmary to care for the sick They are located near urban centers within easy access *of transportation* to facilitate visiting among residents and relatives and *friends* An example of this type of housing

for the aged has been constructed by the Intercommunale of Social Work in the region of Charleroi near Brussels and consists of 240 beds in pavilions of 50 beds each

The ill aged will require more specific medical care and the trend supported by the Ministry of Public Health and the Family, is to establish centers of geriatry for the care of the acutely and chronically sick aged These centers will provide medical and surgical care and will include such specialist services as eye dental, chest cardiac X ray and neuropsychiatry and physiotherapy consultations and treatment They will be equipped with laboratories for clinical research and a center for rehabilitation and will be in close contact with the medicosocial services which the aged will need They are planned as centers for active diagnosis and treatment where a patient will spend a minimum of time in the hospital and will be promptly discharged as soon as the hospital is no longer his proper place In this setup the rehabilitation center will play an important role in re-education to prevent disability and to upgrade existing incapacities so that the old person will be able to manage the essential needs of daily living for himself Patients attending the rehabilitation center remain under regular medical supervision and recreational activities and occupational therapy are integrated into the rehabilitation program

At present there is a center of geriatrics at Charleroi with about 80 beds and the Intercommunale of Social Work of the Region has a project for a hospital of 600 beds for the aged acute and chronic sick At Duerne a special hospital for the chronic sick has recently been opened and it is independent of the nursing home which is in this area Projects are under way for the construction of other centers at Louvain Tirlemont and Antwerp

The aged well and the aged infirm who can still manage to look after themselves fairly adequately will get along at home if provided with some conveniences and help Special housing home help, domiciliary care and other social services have enabled many old people to live in their own homes "Meals on wheels" help with laundry and foot care have been started in some areas and plans to extend these services to a larger number of old people have been made

Public interest in the welfare of old people has been stimulated through programs of information and education by official and voluntary organizations and funds are collected which help to support some of the services for the old during an annual Week for the Aged (Belgium Commission de Co ordination de l Office d Identification 1957a 1957b)

F Medical Care in Italy

Italy also faces the problem of an increasingly larger aging population In the nineteenth century migration drained her of her younger adults and even today the younger adults seasonally migrate to find employment in other countries or live temporarily outside their country returning to spend their old age Since World War II Italy has been facing pressing social political and economic problems Her sociomedical resources have gone into providing for the needs of all ages so that although the problems of population aging concern her no special facilities have been developed for the aged

The care of the healthy aged is not a community problem Maintenance of traditional and close family links has preserved the status of the old in the pattern of family life There are throughout Italy 1761 institutes devoted to the care of old people which accommodate 83 680 aged an additional 400 institutes care for other categories of people but also have rooms for old people (Canaperia personal communication) Many of these institutes are centuries old originally established through the bounty of wealthy families but now depending mainly upon contributions from local municipal and provincial administrations for their maintenance An important percentage of these institutes is attached

to and run by, some religious order Others are directed by municipal and provincial administrations

Many of these institutes preserve a proud tradition of service to the aged Since its beginning in the fourteenth century, S Lorenzo in Venice has always allowed its guests to have their own rooms and kitchenette with their own furniture and personal belongings Others are more rigid in their administration but there is a trend toward the new concepts of caring for the aged Plans for modernizing the old buildings of these institutes into more comfortable dwellings and transforming their large dormitories into smaller rooms with one two or four beds are under way

The administrators of these institutes have founded the Italian Gerontological Association which publishes a monthly journal dealing with the problems of geriatrics and organizes seminars and conferences for administrators social workers and others employed in the care of the aged

Most sick old persons are cared for in the wards of general hospitals Italy is only at the beginning of a movement toward the development of special care of old people in general hospitals and only a few hospitals have geriatric wards. Besides the general hospitals there are special hospitals *cronicari* for the care of the chronically ill for whom there is no hope of rehabilitation The *cronicari* are less well equipped than the general hospitals and comprise 9892 or 5 3 per cent, of a total of 188 285 available beds in Italian hospitals However the majority of patients aged 60 years and over are cared for in the wards of general hospitals In 1954 of a total of 1 821 000 patients admitted to general hospitals 243 730 or 13 4 per cent were 60 years or older (see Table 4)

G *Medical Care in the Federal Republic of Germany*

Germany also faces the problem of an increasing number of old people in her population The proportion of persons 65 years and over was 4 8 per cent in 1880, 7 5 per cent in 1939, and 10 per cent in 1955, and, by 1972, it is estimated that this age group will comprise 13 per cent of the population (World Health Organization, 1955) Germany has had for a long time a scheme of sickness insurance (*Krankenkassen*) under which medical care is provided to a large proportion of the population Of a total of 7 499,522 persons receiving medical care under this scheme, 350 183 were aged 60 years and over in 1955 (Germany [West] Statistisches Bundesamt, 1955)

Homes for the aged existed in Germany before the war In 1955 there were 2384 welfare homes for the aged in West Germany with 111,000 beds, and there are many plans for the construction of additional homes for old people In Hanover the church home mission plans two homes for aged married couples At present there is an awakening interest on the part of religious governmental, and voluntary organizations in providing care and services to old people In 1954 an "Age Academy" was formed under the auspices of the church in Hemer (Rhineland/Westphalen) and in co-operation with state, welfare, medical, and voluntary organizations, organized discussions on all phases of the problems of the aged which should stimulate creation of facilities and services that old people need A center of activity in behalf of the aged is in Frankfurt, and a great deal of public interest has been aroused in providing sociomedical care for the aged (Vaster, 1957)

III Rehabilitation

[illegible]

[illegible] western countries during the past decade there has been a surge of professional and public interest in rehabilitation as an essential part of the total effort to solve the social and economic problems that medical progress has created Persons

who a few decades ago would have died from acute communicable diseases now live but in later years acquire disabling illnesses Each year medical advances are made that prevent death but leave the survivors with severe disabilities Until medicine provides specific answers to the problems of diseases of the heart and circulation, arthritis, and other chronic diseases a dynamic co ordinated program of total rehabilitation, physical and social, will be necessary to train these survivors to live as effectively as possible within the limits of their capacity (Rusk, 1956b) As Rusk points out, the problems of chronic diseases can be met not by building more facilities for care but by utilizing, and creating wherever possible, abilities of the disabled Rehabilitation exploits fully what capacity is left to restore function, physical and psychological, and to return independence, dignity, and meaning to the life of the disabled It protects community resources and allows the best use to be made of hospital beds and patient care institutions and services

Much of the disability and ill health of old people is the result of medical neglect Now that the mathematical chance of surviving to old age has increased, a more positive approach to the incurable diseases of this period of life is needed to avert the personal frustrations and community problems that accompany physical disability and mental ill health The medical profession is beginning to realize that old people do respond to treatment and can recover function to a surprising degree Until recently the tendency has been to protect the old person, because of age and frailty, from a battery of diagnostic procedures and therapeutic armamentaria Geriatric medicine must combat this attitude if a considerable number of old people are to be saved from disability and from occupying hospital beds for a long time and overcrowding hospital facilities The average number of days of hospitalization is twice as long among persons over 65 years than among those under 65 years (Rusk 1956b) Chronic illness and disability in old persons call for active medical treatment and rehabilitation if they and the community are to be spared the consequences of neglect

Rehabilitation begins with the beginning of medical treatment, either at home, in the outpatient department, or in the hospital ward Medical treatment has significant purpose when the patient is considered as a whole The recovery of physical function in a damaged organ may be incomplete medically, but, if the aged patient can resume his usual life and do what he needs and wants to do, and can maintain a state of physical, psychological, and social harmony with his environment then he has recovered and is in a state of health within the flexibility of Sheldon's definition "normal for age" For example, various surveys have shown that, in reply to questions assessing physical fitness and health a surprising number of old people rate themselves in a good state of health only to be classified after medical examination as not being healthy It appears that as long as the individual is able to function adequately in his environment he does not consider his heart disease or residual paralysis as reasons for assessing himself in a bad state of health

It is important to undertake physical psychological social and environmental assessment of the patient's condition and needs before beginning rehabilitation This can be done through the co operative effort of doctor social workers, and nurses and should ideally begin in the home before the patient's admission to the hospital or geriatric unit

A psychological assessment is extremely valuable since the success of any rehabilitation measure depends perhaps even more on the patient's emotional adjustment and psychological makeup and his desire to get well than on medical results Knowledge of his background is valuable in understanding and treating him, and a social and environmental assessment gives a picture of the patient and his illness in the

light of his domestic and family life This is essential for rehabilitation which includes the recovery of domestic and family relationships disturbed by illness

Rehabilitation can be carried out in hospitals clinics convalescent homes, clubs and even in the patient s home, according to the facilities for caring for the aged developed in each country Patients must participate actively in their treatment Contrary to general belief, old people do not like to be overprotected and coddled and are capable of and desire much more activity and independence than they are usually allowed

Rusk distinguishes three groups of patients who need rehabilitation (1) the obviously handicapped—patients with hemiplegia arthritides fractures amputation and neuromuscular disease (2) the chronically ill without signs of a manifest disability—chronic cardiacs chronic pulmonary disease and (3) the elderly person who is not obviously ill but whose physical fitness is impaired so that he is unable to perform his everyday functions without difficulty (Rusk and Dacso 1956) The latter group is perhaps, the most neglected medically among the aged and the one which will benefit greatly from some form of rehabilitation therapy

Rehabilitation is an essential part of hospital treatment and should begin whenever a healthy old person first becomes a sick patient After assessing the need for admission to the hospital the patient should be prepared psychologically for the change in environment which may cause confusion incontinence and physical disorientation In all events hospitalization should be undertaken with proper respect and all due care Treatment should begin as soon as possible after admission and continued actively until the maximum result has been achieved and no further benefit can be expected from a continued hospital stay and then the patient should be discharged without delay (Exton Smith 1955) Immobilization in bed results in physical and psychological complications and is to be avoided Ward routine should be modified for each patient after the acute stage of his illness has passed to preserve and restore physical and social capacities The accepted reasons for keeping patients in bed are not valid for the elderly (Amulree *et al*, 1951) At the Sabbatsberg Hospital every patient must be out of bed for some time every day, and many ingenious devices and adaptation of equipment have been utilized to help the old people do for themselves (United Nations 1952, Hilleboe 1955) Rails in halls slings over bath tubs low beds special wheel chairs that can be propelled with one hand, high chairs with high rounded arms and backs to support old bodies that spend so much time seated and many other personal tools help the old person to take care of himself Learning ability even of those in the eighties is remarkable Many have been able to learn a new language or to relearn speech that has been lost after a cerebral accident as well as to weave or knit In Copenhagen at the Old People s Town older patients are also urged toward early ambulation even if frail, feeble and disabled (Hilleboe 1955) Early ambulation eases the strain on the nursing and hospital staff and helps to increase the patient s self-confidence

While in bed the elderly should have skin and toilet care and position should be changed frequently Passive exercises putting the joints through a maximum range of movement at least once daily should be done to prevent loss of muscle tone or stiffness and deformity of the joints As soon as possible active exercise requiring active participation on the part of the patient should begin Later communal exercises in a gymnasium provide social contacts and help to maintain mental alertness and stimulate greater physical activity as well as save the therapist s time.

Occupational therapy is another important adjunct in testing and restoring skills lost through illness or adverse psychological reaction to the restrictions of advanced age or enforced retirement. After training in the activities required for daily living

the elderly may be able to return to his former independence, and many women may even be able to take up again their domestic and household tasks Occupational therapy dispels boredom, stimulates alertness by developing new interests, hobbies, and talents, and may become the means of providing economic independence for some elderly persons Success and pride in achievement build up self confidence and help to maintain the individual's social integration

Howell (1950) prescribes group remedial exercise in the gymnasium for his arthritics Every effort is made to stimulate interest in exercises and games, and the old people often find themselves doing much more than they realized themselves capable of doing Howell alternates occupational therapy, on wards for the bedfast or in the workroom, with exercise days For movements of the shoulder joints heavy rug looms are employed Table looms are used by patients needing to exercise movements of elbows wrists, fingers, and knees Making knotted woolen rugs on a stringed frame or more complicated and strenuous basket work is used as a good exercise for arthritic fingers Knitting is forbidden since it requires so little movement that ankylosis often occurs while doing it The old fashioned treadle sewing machine exercises stiff ankles and leather work and sewing aid in keeping joints supple Helping with ward routine gives the patient the satisfaction that comes from performing a job whose usefulness to the ward community can be immediately appreciated and is a first step to the realization that personal independence is possible for him

The potentialities for rehabilitation of the chronic sick are great, and patients selected after thorough examination diagnosis, and classification respond to suitably graded programs A group training course organized by the United Nations (1952) lists the following four principles of rehabilitation in the aged (1) an active regime from a mental and physical point of view within the capabilities of the patient, (2) precise diagnosis and etiology of the disease, (3) an energetic graded regime and (4) occupational therapy to maintain and improve the patient's zest for living

The rheumatic diseases, circulatory disturbances, central nervous system lesions such as hemiplegia, dietetic deficiencies and some psychological states are amenable to improvement on appropriately graded regimes Since rehabilitation procedures are based on physical activity, the status of the circulatory system and response to exercise should be carefully assessed at the beginning and throughout the period of therapy

Exercise plays an important role in maintaining the efficiency of the body, and both functional capacity and tolerance to exercise can be increased with training Well compensated cardiacs are capable of a surprising degree of activity, and they should be encouraged to participate in all programs which will help to maintain and increase their capacity for activity and work In economic situations which absorb them aged compensated cardiacs are able to work satisfactorily under medical supervision when selectively placed under favorable conditions in regard to kind and hours of work opportunity for rest difficulty of travel and other stress factors involved

Hemiplegia is one of the most common disabilities treated by rehabilitation The hemiplegia may be due to cerebral hemorrhage or more usually to cerebral thrombosis which may result in a variable clinical picture Since the elderly may also have general cerebral arteriosclerosis both factors must be considered in the physical and psychological assessment especially when the patient seems difficult and uncooperative The clinical picture and response to medical treatment must be evaluated in relation to the extent of brain damage which will also influence the final capabilities of the patient Two-thirds of the patients surviving the initial shock learn to walk again Rusk found the average training time for his hemiplegics to be 6 weeks An analysis of the first 1000 stroke cases

from Bellevue showed that, after an average training time of 7 weeks, 900 patients were ambulatory and able to meet the needs of daily living and outside institutions and that 400 were able to go back to some kind of gainful work. The average age of the patients was 63 years and the average time from stroke to beginning of treatment was 9 months (Rusk, 1956*a*). Abramson (1955) reports among his patients in New York City less than 2 per cent of patients unsuitable for rehabilitation, while 80 per cent could be trained to care for themselves completely; the average age of the older group being 62 years.

Both Howell (1950) and Exton Smith (1955) stress the necessity of beginning rehabilitation of the hemiplegic soon after admission to hospital. Immediately after onset good nursing and general care are essential. Infection may cause confusion and simulate a picture of mental disturbance and anemia may also retard recovery. Later treatment depends on the specific local function to be improved. A wide range of exercises, equipment, and mechanical aids for suitably guided movements in learning to stand and walk, the Guthrie-Smith sling for restoring function of the shoulder joint, and speech therapy to overcome language disturbances help patients relearn lost function and make the necessary readjustments for living independently in their environment.

What can be done to reduce disability is demonstrated by an experiment by Howell. He asked 56 bedridden patients at St. John's Hospital "Why can function not be performed?" and in 3 weeks was able to get 49 up and in 2 months 36 were discharged. By grouping ambulatory hemiplegics, mobile arthritics and convalescent pneumonias by functional recovery rather than structural lesion in cheerful wards he was able to encourage independence and release nursing service to more needy wards (Howell, 1950).

Marjory Warren (1955), reporting on the treatment of 18 double amputees admitted to the Geriatric Unit of the West Middlesex Hospital, discusses the rehabilitation and management of these patients and shows the effectiveness of new methods of treatment adapted to the special problems presented by individual patients and the importance of regular medical follow-up. Of 18 double amputees of the lower limbs 11 were educated to walk on pylons, and 5 could climb stairs.

The statistical results of rehabilitation in the Old People's Town in Copenhagen show the importance of beginning rehabilitation as early as possible in ambulant geriatric clinics (Porsman, 1955). The Old People's Town accommodates old people who can look after themselves and others who need more medical and nursing care. It has a general department for residents partially able to look after themselves and an infirmary for bedridden patients. Porsman reports the results of rehabilitation of 325 patients admitted to the infirmary from *July 1, 1952*, to January 1, 1954, and concludes that "the results would be considerably better if treatment were commenced before the patients were disabled *to such an extent* that admission to a hospital is necessary." Of 26 patients with rheumatoid arthritis who were bedridden at the beginning of rehabilitation treatment, only 3 were fit enough to be discharged to the General Department or Nursing Department of the Old People's Town or to their own homes, and, of 50 patients with fractures of the lower extremities also bedridden at the beginning of rehabilitation, the corresponding discharges were 22. Dementia was the most frequent reason for the failure of rehabilitation because these patients were unable to co-operate. Porsman ascribes the dementia in some cases to the feeling of patients that their doctors had "given them up" and also to the leaving of familiar homes for an old age welfare institution.

IV. Preventive Measures

Stieglitz (1949) has said that, "if increased longevity is associated with health

the elderly may be able to return to his former independence, and many women may even be able to take up again their domestic and household tasks Occupational therapy dispels boredom stimulates alertness by developing new interests, hobbies, and talents, and may become the means of providing economic independence for some elderly persons Success and pride in achievement build up self confidence and help to maintain the individual s social integration

Howell (1950) prescribes group remedial exercise in the gymnasium for his arthritics Every effort is made to stimulate interest *in exercises and games, and the old people* often find themselves doing much more than they realized themselves capable of doing Howell alternates occupational therapy, on wards for the bedfast or in the workroom with exercise days For movements of the shoulder joints heavy rug looms are employed Table looms are used by patients needing to exercise movements of elbows wrists fingers and knees Making knotted woolen rugs on a stringed frame or more complicated and strenuous basket work is used as a good exercise for arthritic *fingers Knitting is forbidden since it re*quires so little movement that ankylosis often occurs while doing it The old fash*ioned treadle sewing machine exercises stiff* ankles and leather work and sewing aid in keeping joints supple Helping with *ward routine gives the patient the satisfac*tion that comes from performing a job whose usefulness to the ward community can be immediately appreciated and is a first step to the realization that personal independence is possible for him

The potentialities for rehabilitation of the chronic sick are great and patients selected after thorough examination diagnosis, and classification respond to suitably graded programs A group training course organized by the United Nations (1952) lists the following four principles of rehabilitation in the aged (1) an active regime from a mental and physical point of view within the capabilities of the patient, (2) precise diagnosis and etiology of the disease, (3) an energetic graded regime and (4) occupational therapy to maintain and improve the patient s zest for living

The rheumatic diseases circulatory disturbances, central nervous system lesions such as hemiplegia, dietetic deficiencies, and some psychological states are amenable to improvement on appropriately graded regimes Since rehabilitation procedures are based on physical activity, the status of the circulatory system and response to exercise should be carefully assessed at the beginning and throughout the period of therapy

*Exercise plays an important role in main*taining the efficiency of the body, and both functional capacity and tolerance to exercise can be increased with training Well compensated cardiacs are capable of a surprising degree of activity and they should be encouraged to participate in all programs which will help to maintain and increase their capacity for activity and work In economic situations which absorb them, aged compensated cardiacs are able to work satisfactorily under medical supervision when selectively placed under favorable *conditions in regard to kind and hours of* work opportunity for rest difficulty of travel and other stress factors involved

Hemiplegia is one of the most common disabilities treated by rehabilitation The hemiplegia may be due to cerebral hemor*rhage or more usually* to cerebral thrombosis which may result in a variable clinical picture Since the elderly may also have general cerebral arteriosclerosis both factors must be considered in the physical and psychological assessment especially when the patient seems difficult and unco operative The clinical picture and response to medical treatment must be evaluated in relation to the extent of brain damage which will also influence the final capabilities of the patient Two-thirds of the patients surviving the initial shock learn to walk again *Rusk found the average train*ing time for his hemiplegics to be 6 weeks An analysis of the first 1000 stroke cases

written "Where the ideal of prophylaxis of infections and of other causes of morbid action is attained, a healthy old age and physiological death without attendant disabilities and horrors should be the common lot of man, instead of being somewhat exceptional in the case of the first, and extremely rare as regards the final act"

Preventive health examinations are being done through health and welfare centers in Oslo, and instruction and retraining for later years are begun at age 50 (Delore 1955) The Consultative Health Centre in Rutherglen Scotland (Anderson, 1955), for people over 54 years was started in March 1952 with the basic idea of integrating 'available services for old people *in an endeavour* to keep them in a sound state of physical mental and social well being' The functions of the center are listed below and serve as an illustration of the services and guidance possible in a preventive center

1 To act as a source for the spread of information relating to the promotion of health and the prevention of disease
2 To compile a register of the elderly living within the *district*.
3 To examine healthy old people at routine intervals and to wage a search for early and unsuspected disease.
4 To integrate treatment with the social environment through care and aftercare work.
5 To reduce the demand on hospital beds *to* a minimum
6 To provide a citizens advice bureau for old people
7 To carry out research into the aging process

C General Education of the Public

An important preventive measure in geriatrics is general education of the public in matters of health protection Although the childhood of the already aged is beyond reach knowledge that a happy childhood is the best security for old age is good health education for the parents of today and will benefit the young who will arrive at the end of the life table some day Attention has been drawn to the possibility that character formation and emotional development in the early years of childhood influence adjustment to others in old age (Lamont, 1953) Mental attitudes in old age reflect attitudes of earlier life To maintain the mental health of the aged it is important to start early in acquiring and keeping alive indoor and outdoor interest, cultivating and nourishing friendships, and developing the proper balance among work, rest, and recreation The old as he relinquishes the active pursuits of maturity must be reoriented to accept his new status which carries new values and potentialities Education of the young directed to molding an attitude which accepts old age as a normal part of the social pattern for which they assume responsibility *now*, and a status to which they can look forward in the future, will create and strengthen a society which provides security in old age

Dissemination of information to the public on the problems of old age, on the services available to old people, and *on* how to obtain such services is as *important* an aspect of health education as stimulation of the state and responsible authority to provide wisely and adequately for the old

D Gerontological Research and Professional Education

Gerontological research must be stimulated and supported in order to advance our knowledge of the biology and clinical manifestations of aging as well as the diseases of particular significance in later life, such as cardiovascular diseases and cancer, and of how to provide health care to the aged

Professional education also must recognize the needs of geriatric medicine and provide the training that doctors nurses social workers, and other paramedical workers will need if they are to fulfil their function in the program of care for old people The single unit best equipped to practice preventive geriatrics and geriatric medicine is the general practitioner, for

and useful vigor during the declining years, it may be an immensely valuable asset especially if these potentialities of the elderly are wisely developed, guided and utilized" This goal can be achieved through promotion of health, prevention, curative treatment, rehabilitation, and research

Health promotion and prevention aim to save the old from a state of "medicated survival" so that the average man of 75 in the future will maintain as maximum a *degree of alertness and vigor as is biologically* and physiologically possible This preparation for old age must begin before the onset of old age Churchill has said that all the world can be young but that, to come there, one must begin on the way early

A Good Nutrition

Heredity and nurture are important in longevity At the present state of knowledge, preventive measures can be more realistically applied to the exogenous and environmental factors of aging The evidence, largely based on animal experimentation, of Sinclair (1955) and others suggesting that overfeeding in childhood causes early maturation and shortens life and that overfeeding after maturity increases the incidence of certain degenerative diseases that are common in old age emphasizes the role of nutrition from the earliest years of life Good nutrition is important in building good body tissue and a nutritionally adequate diet from childhood on is reflected in the structural and functional adequacy of aging tissues Premature physiological aging can be prevented by applying the principles of good nutrition

B Preventive Health Centers

Preventive health centers should also be an integral part of medical care programs for the aged Early recognition and early diagnosis of morbid processes are important in preserving the health of the aged The report of the Committee of the Care of Chronic Illness and the Aged at the Ninth International Congress of Hospitals at Lucerne in 1955 recommended a further study into the creation of preventive medical centers in the framework of the general hospitals and geriatric services (Delore 1955) These centers can carry on health education to advise the middle aged person how to preserve his health and prepare sensibly for advancing years They can also do periodic medical examinations to assess health and prevent illness and disability, *to detect and treat early deviations from* the "normal," and to control disease processes that are not curable

Wibaux (1956) places the responsibility for preventing diabilities of old age upon each individual He states that no individual has the right to illness and impotence which will necessitate care and help for which society has to pay, so it is his obligation to keep himself well and protect himself from accidents He suggests a first preventive health examination at the age of 50 when advice for health protection based on the findings of the examination should be given A second examination should take place at age 60 when the individual is urged to follow a strict regimen of health care, and a third examination should be mandatory at age 70 when it is absolutely exigent that advice and treat*ment be followed* The pressure of modern life usually does not allow for radical modifications in the pattern of living and the old, if well, will find it difficult to accept changes that are not immediately and specifically directed toward correcting an existing abnormality Continued effort must *be made to get the young to realize the* goals and value of periodic health examinations and to form attitudes which will carry over into old age

The ages given by Wibaux are already too late to begin preparation for avoiding the physical and psychological hazards of aging but they suggest good stopping points for health assessment to prevent infirmity and disability arising out of conditions that might be uncovered by periodic examination Rolleston (1922) has

Old age in the modern world, pp 534–40 (
Edinburgh E & S Livingstone
BASTAI P, and DOGLIOTTI, G C 1938 Physio pathologie de la vieillesse et introduction à l'etude des maladies des vieillards Paris Masson & Cie
BELGIUM. COMMISSION DE COORDINATION DE L'OFFICE D'IDENTIFICATION 1957a Les problemes de la vieillesse, Vol 1 En Belgique (Cycle de conferences présentees aux réunions de travailleurs sociaux de la Commission de Coordination, septembre 1955—
— se ées
aux journees internationales d etudes organisées par la Commission de Coordination, 7 11 novembre 1956) Brussels
BERG G 1954 Befolkningsutveckling och sjukvardsbehov i Stockholms lan I Svenska Lakartidningen 51, 1097–1121
—— 1957 Introducing chronic bronchitis National Association for the Prevention of
BRC
Ziekenhuiswezen 30, 305–14
BRULL, L 1954 Problèmes de gériatrie Rev méd Liége, 9, 202 5
CANNON W B 1939 Ageing of homeostatic mechanisms *In* F V COWDRY (ed), Problems of ageing pp 623–41 Baltimore Williams & Wilkins Co
CLERENS J 1956 Problèmes de gérontologie Tech Hosp 11 (May), 28–30
COMFORT A 1956 The biology of senescence London Routledge & Kegan Paul
COVALT, NILA K. 1956 European approach to rehabilitation of older people J Am Geriat rics Soc., 4, 235–41
et prolongation de la vie active
— *In* European seminar on social services for the aged, Liege, 1955 Geneva United Nations
DE
— mittee To Study and Investigate the Care of
—— 1956*b* The old in modern society *Ibid*, June, pp 15–17
DELORE, P, and ARNAUD, P 1956 Motifs d hospitalisation des malades âgés de plus de 65 ans Tech Hosp, 11 (August-September), 48–53
DUNBAR, FLANDERS 1955 The long lived ageing and illness *In* Old age in the modern world, pp 412–20 Edinburgh E & S Livingstone
DURAND, J D 1955 Demograph
EK
ganisations médicales Tech Hosp, 11 (February), 32–36
EVANS F T 1956 Anaesthesia for the elderly *In* W HOBSON (ed.), Modern trends in geriatrics London Butterworth & Co
EVANS G 1955 Comprehensive care of old people the role of the local authority welfare department. *In* Old age in the modern world pp 84–95 Edinburgh E & S Livingstone
EXTON SMITH, A. N 1955 Medical problems of old age Bristol John Wright & Sons
FOOD AND AGRICULTURE ORGANIZATION 1950 Report of the Committee on Caloric Re-

steadily more and more of his professional time is occupied in the care of the old The students of medical and allied professional schools must be oriented to the geriatric aspects of their courses, and, where indicated, the curriculums should include courses that deal with the specific problems of geriatric medicine

Since medical care of the old is only one phase in the over all need of the aged, all preventive measures in the field of health, housing, employment, and social security must be co ordinated and integrated to achieve a maximum of result at a minimum cost to private and public funds Not only must the medical care of the old be treated as a whole but his total care must be related to the aggregate of his medical, social, and economic needs

V Conclusion

Increasing interest in gerontological activities on the part of individual countries (as well as international organizations) reflects the growing concern of countries in the increasing proportion of aged persons in their populations, and conferences and studies into the nature and extent of the problem and the best means of meeting it are being undertaken or planned Among recent meetings in which several countries have participated may be mentioned the Advisory Group on the Public Health Aspects of Aging of Populations held by the Regional Office for Europe of the World Health Organization in Oslo in July, 1958 (1959*b*), an Expert Committee on the Mental Health Problems of Aging and the Aged held by the World Health Organization in Geneva in September, 1958 (1959*a*), and a Seminar on the Individual and Social Importance of Activities for the Elderly held under the auspices of the European Office of the Technical Assistance Administration of the United Nations in Konigswinter, Germany, in October, 1958 (1959).

The conclusions reached at the technical discussions of the Fifth Session of the Regional Committee for Europe of the World Health Organization summarize the trend in the medical care of the aging population in European countries Home care is emphasized as being the most desirable and to be encouraged whenever it is medically possible in terms of all the specific health and social services previously enumerated Adequate home care and, in fact, the entire program of sociomedical care can be achieved only through the wholehearted co operation of medical, voluntary, and official or government bodies on all levels of administration and implementation of services Hospitalization, when necessary, should be for active diagnosis, treatment, and rehabilitation and should be geared to achieve the maximum therapeutic benefit in a minimum of time and with a view to returning the patient to his usual environment in the same, or a higher, level of health so that he may be able to maintain a fairly independent existence or to get along with a minimum of help

The old need the same facilities of high quality care as the young for both acute and chronic diseases In order to assure care of high caliber for the chronically ill old, without unduly burdening existing hospital facilities, special geriatric services may be required The geriatric service is envisioned not as a place for permanent care but as an active service where a considerable number of patients (up to 70 per cent) should be ready for discharge in 6–7 weeks

References and Bibliography

Abramson A S 1955 Rehabilitation in geriatric practice Canad M A J 72, 327 34

Amulree, (Lord) B W S 1953 The formation of a geriatric service Tech Hosp 8 (May) 22 25

Amulree (Lord) B W S, Exton Smith A N, and Crockett G S 1951 The proper use of the hospital in the treatment of the aged sick Lancet, 1, 123–26

Anderson, W I 1955 A clinical study of the patients attending a consultative health centre for old people at

PFISTER, H. O 1951 Chronic invalids *In* VII International Hospital Congress, Brussels, 1951 London International Hospital Federation.
PORSMAN, V A. 1955 Statistical results of rehabilitation in "The Old People's Town" in Copenhagen. *In* Old age in the modern world pp 571-74 Edinburgh E & S Livingstone
ROLLESTON, H. D 1922 Some medical aspects of old age London Macmillan & Co.
ROTH, J 1955 Old age insurance and welfare in Switzerland *In* Old age in the modern world, pp 62-65 Edinburgh E & S Livingstone
ROWNTREE, B S 1947 Old people London Oxford University Press (for the Nuffield Foundation)
RUSK, H. A. 1956a Sick people in a troubled world Laryngoscope, 66, 1094-1112
——— 1956b [illegible]
RUSK, H. A, and DACSO, M M 1956 Rehabilitation in the aged. Bull. New York Acad Med, 32, 725-33
SAUVY, A. 1955 Age and society the historical and sociological basis *In* Old age in the modern world, pp 28-32 Edinburgh E & S Livingstone
SCHULZE W 1955 Protein metabolism and requirement in old age *In* Old age *in the* modern world pp 122 27 Edinburgh E & S Livingstone.
SHELDON, J H 1948 The social medicine of old age. London Oxford University Press (for the Nuffield Foundation)
SHOCK, N W, WATKIN, D W, and YIENGST, M J 1955 Metabolic aspects of ageing *In* Old age in the modern world, pp 127-37 Edinburgh E & S Livingstone
SINCLAIR H M 1955 The dangers of overfeeding *In* Old age in the modern world, pp 106-13 Edinburgh E & S Livingstone
——— 1956 Nutritional problems of the elderly [illegible]
[illegible] pp 441-51 Edinburgh E & S Livingstone.
SMITH, R. C. F 1957 The effect of social problems on the lives of old age pensioners M Officer, 97, 303-8
SPIEGELMAN, M 1954 An international comparison of mortality rates at the older ages *In* World Population Conference, 1954, Papers, Vol 1, Meeting No 2, pp 289-309 Geneva United Nations
STARE, F J 1956 Nutrition and the geriatric patient J Am Geriatrics Soc., 4, 744-50
SIR HALLEY STEWART TRUST and NATIONAL OLD PEOPLE'S WELFARE COMMITTEE 1954 Over seventy report of an investigation into the social and economic circumstances of one hundred people over seventy years of age London National Council of Social Service
STIEGLITZ, E J 1949 Geriatric medicine the care of the aging and the aged 2d ed Philadelphia W B S[illegible]
[illegible]
S[illegible] J Gerontol, 11, 178-84
SWEDEN 1956 Swedish government's public investigations Stockholm Department of Social Affairs
SWEDISH SOCIAL WELFARE BOARD 1952 Public assistance in social Sweden Stockholm The Board.
SZAFRAN, J 1955 Experiments on the greater use of vision by older adults *In* Old age in the modern world, pp 231-35 Edinburgh E & S Livingstone
THEWLIS, M W 1954 The care of the aged 6th ed St. Louis C V Mosby Co
TOWNSEND, G W H 1955 Making the most of institutional accommodation for the elderly *In* Old age in the modern world, pp 76-80 Edinburgh E & S Livingstone.
TUNBRIDGE, R. E 1951 Problems of prolonged illness *In* VII International Hospital Congress Brussels 1951 [illegible]
[illegible] adult disabled report of a group training course organized by the U N with co-operation of the WHO and the ILO ST/TAA/Ser C/4, pp 49-51
——— 1959 European seminar on the individual and social importance of activities for the elderly (UN/TAA/SEM/1958/Rep 3) Geneva United Nations
VAN ZONNEVELD, R. J 1954 Health problems of the aged. Assen van Gorcum & Co
——— 1957 Socio-medical investigations for

quirements ("FAO Nutritional Studies," No 5) Geneva United Nations

FREUDENBERG, K 1955 Mortality trends by ages over a period of eighty years in Germany *In* World Population Conference, 1954, Papers, Vol 1, Meeting No 2, pp 77–88 Geneva United Nations

GAUSTAD, V 1956 Project for organizing hospital and home services for the aged in Oslo Tech Hosp, 11 (March), 40–43

GAVEY, C J 1949 The cardiology of old age Lancet, 2, 725–36

GERMANY (WEST) STATISTISCHES BUNDESAMT 1955 Gesundheitswesen Statistische Ergebnisse 1955 Statistik der Bundesrepublik Deutschland, Vol 174 Wiesbaden

GIJSBERS, A 1956 Symposium on home services *In* European seminar on social services for the aged, Liege, 1955 Geneva United Nations

GOSSET, A 1953 Les vieillards en établissements hospitaliers l amérlioration du sort des gens âgés Journées Régionales d Études Organisées par la Délégation Régionale du Nord de l Alliance Nationale contre la Dépopulation Collection Informations Sociales L'Union Nationale des Caisses d'Allocations Familiales Paris

GREAT BRITAIN NATIONAL HEALTH SERVICE 1957 Geriatric services and the care of the chronic sick London H M Stationery Office

GRAILLY, R DE, and DESTREM, H 1953 Physiologie générale, diététique et comportement de la vieillesse Paris Masson & Cie

GREENLEES, A, and ADAMS, J 1950 Old people in Sheffield Sheffield Council of Social Service 1950

GROLLMAN, A. 1955 The interrelationship of

Hi

Denmark, Norway, and Sweden Geriatrics, 10, 541–48

HIPPOCRATES 1943 Loeb Classical Library, Vol 4 London Heinemann

HOBSON, W, and BLACKBURN, E K 1953 Haemoglobin levels in a group of elderly persons living at home alone or with spouse Brit. M J, 1, 647–49

HOBSON, W, and PEMBERTON, J 1955 The health of the elderly at home London Butterworth & Co

HOBSON, W, and ROSEMAN, C 1953 A dental survey of a group of old people living at home Brit Dental J, 94, 208

HOWELL, T H 1950 Old age London H K Lewis & Co

——— 1953 Our advancing years London Phoenix House

——— 1956 Basic problems of the aged and chronic sick J Am Geriatrics Soc, 4, 224–34

HUET, J A 1957 The impact of illness of aged people on the economy of Parisian hospitals *In* Proceedings of the Fourth Congress, International Association of Gerontology, Merano, Italy, 3, 366–74 Fidenza Tipographia Tito Mattioli

HUTCHINSON, B 1954 Old people in a modern Australian community Melbourne Melbourne University Press

IRVINE, E D 1954 Medical aspects of aging *In* Living longer some aspects of the problems of old age London National Council of Social Service

KINDSTRAND, W 1947 Den geriatriska enheten som form for aldringsvård och var för? Social Medicinsktidskrift, No 4 (April), p 145

KRAG, C L, and KOUNTZ, W B 1950 Stability of body function in the aged J Gerontol, 5, 227–35

LAMONT, D J 1953 The role of the health visitor in the care of the elderly M Officer, 92, 162

LOGAN, W P D 1953 Studies on medical and population subjects (General Practitioners Records" No 7) London H M Stationery Office

MAGDELAINE M, and PEQUIGNOT, H 1957 Les besoins d hospitalization des vieillards et leurs causes *In* Proceedings of the Fourth

[illegible]

MINISTRY OF HEALTH AND THE PUBLIC HEALTH LABORATORY SERVICE 1951 52 Monthly [illegible] 10,

[illegible] for [illegible] lish

Social Welfare Board (Mimeographed)

NORGAARD, A 1955 Blodtrykket hos aldre personer med fuld førlighed Nord med, 53, 311–13

PASTOR, A P VON 1957 Neue Ziele der Altenpflege und Altersfursorge in Deutschland Ztschr Praventivm [illegible]

VII

The Mental Health of the Aging[1]

ROBERT W. KLEEMEIER

I Introduction

Mental health is difficult to define Although it refers most directly to a state of being of the individual, it can be used with broader connotation Surrounding it is an aura implying a positive approach to mental illness, a concern with prevention of mental disease, and an interest in the adjustment process of the individual as well as in community conditions which influence individual adjustment.

Good personal mental health is associated with the absence of mental distress, with good adjustment, feeling of well being high morale and happiness In the final analysis however, it is not an absolute condition Rather it refers to the relative success of the individual in dealing with his own emotional stress as shown by the quality of his interpersonal relationships the relative effectiveness of his stress reducing behavior, and his attitudes and self-concepts Intellectual capacity is also related—not that the possession of great ability is the prerequisite for good mental health, or even insures it for that matter On the other hand, nevertheless, mental deficiency is not compatible with good mental health

At the opposite end of this multidimensional continuum lies mental illness and the incapacitating disorders of character and personality Mental health, to a greater extent than physical health, is a condition in which interdependent social, psychological, and medical factors exert apparent influences Thus in the broad sense of the concept every chapter in this book deals with some important aspect of mental health, because social and economic factors as well as physical health create or relieve stress, thereby changing for better or worse conditions affecting the individual's mental health It is obvious, therefore, that a more limited approach is necessary in the present discussion of the mental health of the aged in various western European countries To aid in this delimitation, the following analysis of the criteria of mental health status of a society is given

A Mental Health of a Society Seen in Three Ways

Social mental health can be considered from at least three distinct vantage points (Kleemeier, 1957*a*, 1957*b*), each of which relate to different sets of criteria

1 Social mental health may be presented as the aggregate mental health of the individuals who compose the society Criteria aimed at evaluating this would be derived from the

[1] I am particularly grateful to the following who gave me great help in my search for information on which to base this chapter Dr Yves Porc'her, Hôpital Henri Rousselle Paris Dr R. J van Zonneveld National Health Research Council, TNO, The Hague Dr A Querido, director of public health Amsterdam, Mr Henning Friis, Ministry of Labor Copenhagen Dr A. Berggren Royal So [illegible] So[illegible] the [illegible] et[illegible] [illegible] I am almost equally indebted.

the benefit of the accommodation of the aged J Gerontol, 12, 441–42 (Abstract)

VAN ZONNEVELD, R J, and GROEN, J 1957 A comprehensive study of the aged by general practitioners *In* Gerontological research of the National Health Research Council of the Netherlands Foundation for Applied Research at The Hague and the II Medical Service Amsterdam Wilhelmina Gasthuis

VICKERS, H R, and SNEDDON, I B 1956 Skin changes in the elderly *In* W HOBSON (ed), Modern trends in geriatrics London *Butterworth & Co*

VISCHER, A L, and ROULET, F C 1952 Observations on two centenarians Arch path Anat, 321, 652–63

WALSH, R C 1955 Medical care of old people at home *In* Old age in the modern world, *pp 80–84 Edinburgh E & S Livingstone*

WARREN, MARJORY W 1955 The management of the early double amputee *In* Old age in the modern world pp 562–70 Edinburgh E & S Livingstone

——— 1956*a* Le rôle d'une unité gériatrique *dans un hôpital général Tech Hosp, 11* (February), 37–38

——— 1956*b* The geriatric approach *In* European seminar on social services for the aged, Liege, 1955 Geneva United Nations

WATKINS, E 1951 Housing for the aged report of *WHO fellow three months' study tour,* United Kingdom, the Netherlands, Denmark, and Sweden Geneva World Health Organization

WELFORD, A T 1956 Psychological aspects of ageing *In* W HOBSON (ed), Modern trends in geriatrics pp 69–105 London Butterworth & Co

WIBAUX, R *1956 Les régimes du vieillard* Bull Acad méd, 140, 532

WIBAUX, R, and HUET, J A 1956 Mesures médico sociales à prendre en faveur des gens âgés Tech Hosp, 11 (January), 36–38

WIDDOWSON, E M, and McCANCE, R A 1955 *The response of well nourished old men to* starvation and of under nourished old men to unlimited food *In* Old age in the modern world, pp 113–22 Edinburgh E & S Livingstone

WORLD HEALTH ORGANIZATION 1955 Public health implications of the aging of populations conclusions of a WHO meeting, based on a summary report on the technical discussions of the Vth session of the Regional Committee for Europe Chronicles of WHO, 9, 339–41

——— 1959*a* Mental health problems of aging and the aged Sixth Report of the Expert Committee on Mental Health ("WHO Technical Report Series," No 171) Geneva World Health Organization

——— 1959*b* The public health aspects of the aging of the population (EURO 112) *Copenhagen Regional Office for Europe* World Health Organization

demiological studies of senile mental illness in New York State (New York State Department of Mental Hygiene 1955) Only when many such systematic samples of entire populations are studied will we be able to make reliable national and cross-cultural comparisons of aggregate mental health status Even then unless common criteria are adopted, it will be difficult to arrive at meaningful comparisons (Kleemeier, 1957*a* 1957*b*)

MENTAL HEALTH AS A COMMUNITY OR SOCIAL PROCESS

Just as mental health can be considered as the aggregate mental health of individuals so it can be thought of as a community or social process From this point of view the criterion of community success in dealing with mental health problems is in actuality the effectiveness of its agencies in bringing about the rehabilitation of the mentally distressed (Joint Commission on Mental Illness and Health 1956)

Specifically, this suggests that the criteria of social mental health are established by the rehabilitation rates of psychiatric and other community facilities designed to serve the needs of distressed people The mental health functions of many community organizations—schools churches hospitals clinics physicians social agencies—would thus come within purview

Rehabilitation rates even if they could be reliably established would however, be only the ultimate concern for these are dependent upon prior social medical and even legal processes A thorough survey of all these factors even in a restricted community would be a formidable task and quite impossible at present internationally, for even the tools and methods for doing such research need fashioning and development. Nevertheless some information of the sort required is available, and profitable use can be made of it.

In the countries included in this survey great concern is evidenced over the release and rehabil[illegible] [illegible]tients All are worried over the increasing demands for psychiatric hospitalization and the strains that are being put upon overtaxed and antiquated hospital systems France feels acutely its need for more hospital space and has given the expansion of facilities the first priorities Denmark and to some extent the Netherlands are also engaged in building but all recognize that this is not enough, somehow the number of admissions must be cut or the treatment facilities improved in efficiency so that more patients can be served without excessive burdensome expansion of plant and staff

The Netherlands has pioneered in outpatient services and Great Britain sees hope for the future primarily in this direction Already in England and Wales the mounting tide of hospitalization seems to have been stemmed and during the past few years the number of hospitalized mental patients has been slowly dropping although new admissions continue to rise in number

Related to this vigorous and positive approach to the treatment of mental disease is the turning away from reliance upon legal commitment and certification of patients In some countries in the survey voluntary hospitalization is the rule rather than the exception With this de-emphasis upon compulsion, more and more wards are being unlocked and some hospitals, even those with unselected patients, have no locked wards at all

In this concern with overcrowding thought has been given to the place of the aged patient in the mental hospital Majority opinion is that he does not belong there if he cannot profit by the program of active therapy which should be offered by the mental hospital [illegible]

[illegible] in Denmark, and day hospitals in Great Britain No country has as yet put into action a system which has completely taken care of this problem although some programs are under way

enumeration of individual adjustment characteristics

2 Social mental health may be viewed as a community or social process Here the approaches of the community to the problem of mental health would be sought Treatment and custodial institutions legal and social processes of control of mentally ill persons and activities of the mental health professions would all fall within the purview of this concept

3 Cultural patterns, levels of socioeconomic status environmental factors and social attitudes of a community undoubtedly affect mental health to a far greater extent than we are now clearly able to say It would be reasonable nevertheless to attempt to describe social mental health in these terms

Ideally, a survey of mental health of the aged in western European countries should result in a systematic exploration of all factors related to these three sets of criteria for each country under study Unfortunately, this is too large a job to undertake at present for several good reasons In the first place, it would involve a tremendous amount of original research for relatively little of the required information is to be had for the asking In the second place, it would require a degree of international coordination of effort that could be achieved only after long and careful planning much experience in working together, and considerable dedication to the worthwhileness of the goal Steps in this direction have already been taken, but at best these are preliminary

MENTAL HEALTH CONSIDERED AS THE AGGREGATE MENTAL HEALTH OF INDIVIDUALS

In terms of this criterion we should study the incidence of mental disease in relation to the place of its occurrence—in short, the epidemiology of mental illness Many of the basic data have been and are being currently compiled by hospitals and state agencies, but these are subjected to surprisingly little analysis and study When the data are made available on a national basis, we find that they have been gathered for specific administrative purposes, invariably making cross national comparisons extremely tenuous at best but more often impossible In the following sections some such comparisons will be made, but in general the best that we can hope to do is to gain general impressions from available statistics and to proceed from this to our own conclusions as cautiously as possible

Hospital census data are at best difficult to interpret, certainly, they cannot be used in our present state of knowledge as an index of the national aggregate mental health One obvious reason for this is that hospital admissions depend upon the number of hospital beds available, and these vary as markedly from country to country as they do from state to state in the United States With respect to the aged the inadequacy of this criterion is particularly apparent In most western European countries the feeling exists that the mildly psychotic aged person does not belong in the mental hospital but rather in a separate institution which may or may not be associated with a mental hospital In both England and Denmark the view is expressed that legal certification procedures are being used to overcrowd the mental hospitals with old patients at the expense of the admission of younger patients The Netherlands is in the process of building nursing homes for this group of patients Sweden has an announced policy of separating the physically ill and psychotic from among the residents of its homes for the aged making them the responsibility of the health agencies rather than that of social welfare Such differences in this approach to the mentally ill aged make impossible the assessment of the aggregate mental health of old people through the use of hospital statistics

However an exemplary Swedish study of the incidence of mental illness in the entire population of a small rural area covering an extended period of time has been carried out (Larsson and Sjogren 1954) Unfortunately, there appears to be no European counterpart of the Gruenberg epi

demological studies of senile mental illness in New York State (New York State Department of Mental Hygiene 1955) Only when many such systematic samples of entire populations are studied will we be able to make reliable national and cross-cultural comparisons of aggregate mental health status. Even then unless common criteria are adopted it will be difficult to arrive at meaningful comparisons (Kleemeier 1957*a* 1957*b*)

MENTAL HEALTH AS A COMMUNITY OR SOCIAL PROCESS

Just as mental health can be considered as the aggregate mental health of individuals so it can be thought of as a community or social process From this point of view the criterion of community success in dealing with mental health problems is in actuality the effectiveness of its agencies in bringing about the rehabilitation of the mentally distressed (Joint Commission on Mental Illness and Health 1956)

Specifically this suggests that the cri te

the needs of distressed people The mental health functions of many community organizations—schools churches hospitals clinics physicians social agencies—would thus come within purview

Rehabilitation rates even if they could be reliably established would however be only the ultimate concern for these are dependent upon prior social medical and even legal processes A thorough survey of all these factors even in a restricted community would be a formidable task and quite impossible at *present* internationally for even the tools and methods for doing such research need fashioning and development. Nevertheless some information of the sort required is available and profitable use can be made of it.

In the countries included in this survey great concern is evidenced over the release and rehabilitation of mental patients All are worried over the increasing demands for psychiatric hospitalization and the strains that are being put upon overtaxed and antiquated hospital systems France feels acutely its need for more hospital space and has given the expansion of facilities the first priorities. Denmark and to some extent the Netherlands are also engaged in building but all recognize that this is not enough somehow the number of admissions must be cut or the treatment facilities improved in efficiency so that more patients can be served without excessive burdensome expansion of plant and staff

The Netherlands has pioneered in out patient services and Great Britain sees hope for the future primarily in this direction Already in England and Wales the mounting tide of hospitalization seems to have been stemmed and during the past few years the number of hospitalized mental patients has been slowly dropping although new admissions continue to rise in number

Related to this vigorous and positive approach to the treatment of mental disease is the turning away from reliance upon legal commitment and certification of patients In some countries in the survey voluntary hospitalization is the rule rather than the exception With this de-emphasis upon compulsion more and more wards are being unlocked and some hospitals, even those with unselected patients have no locked wards at all.

In this concern with overcrowding thought has been given to the place of the aged patient in the mental hospital Majority opinion is that he does not belong there if he cannot profit by the program of active therapy which should be offered by the mental hospital Attention is therefore being paid to the setting up of nursing homes as in the Netherlands or hospital annexes in Denmark, and day hospitals in Great Britain No country has as yet put into action a system which has completely taken care of this problem although some programs are under way

Certainly, the place of the home for the aged the geriatric hospital and other institutional and quasi institutional settings must be established in reference to the total mental health problem The separation of the mentally frail aged from the "normal aged person is sometimes difficult and in fact is often thought to be both unnecessary and undesirable In many countries *old people s homes* care for many such individuals Denmark would be ill prepared to accept in its mental hospitals at present all the mentally frail aged residing in its old age homes Even Sweden though she has tried has not yet made the separation complete Elsewhere there is strong feeling that mental frailty in the aged is largely a problem of geriatric medicine with only incidental psychiatric overtones

MENTAL HEALTH AS CULTURAL ENVIRONMENTAL ECONOMIC AND SOCIAL FACTORS

We cannot escape recognition of the fact that an individual s way of life affects in important ways his mental health Whether or not mental illness in any of its forms can ever be considered as the exclusive product of emotional stress arising in the day to day conflicts of life there can be no denying that stress does affect the course of such illness (Kleemeier 1958) Surely a survey of mental health would *be incomplete without consideration of this* factor and the circumstances in the culture which produce it With reference to old people the stress attendant upon such age related conditions as the breakup of the home and family reduction of income upon retirement illness difficult or inappropriate physical surroundings and others would be of transcendent interest This however is an area in which relatively little research has been done although as other chapters in this *Handbook* attest we are not without information *about the basic economic* and social conditions which affect the aged What is lacking however is knowledge of the ways in which mental health of the aged is influenced by these conditions Having emphasized the importance of these factors the necessity for research into the nature of the relationship remains if prevention of mental breakdown is to be accepted as coequal with cure as a primary goal in mental health endeavors

B The Community and the Mental Hospital

Health is not exclusively a medical province although it might be argued that illness is In mental health the lines of medical hegemony are even more indistinct than in what might be considered as purely physical health This is of course apparent if the threefold classification of social mental health criteria described above is accepted We cannot escape however the fact that the major focus of mental health activities are at present medically oriented with primary emphasis upon cure rather than prevention Thus the major mental health resources of the community are the various medical and closely allied professions that exert their therapeutic efforts through clinics hospitals and similar agencies In the following survey therefore these traditional mental health resources are emphasized

Nevertheless this is not a story of isolated institutions and insulated professionals Within the first post World War II *decade great awareness of the plight of* the mentally ill developed in western Europe and North America This interest both resulted in and was stimulated by the organization of mental health associations which grew apace in Europe and America during these years In America they were perhaps more vocal and involved interested lay people to a larger extent but the core of individuals with professional interest in mental health about whom the European associations grew certainly exerted impor*tant influence in their various countries* The efforts of the World Federation of Mental Health and of United Nations agencies continue to improve mental health conditions on a world wide basis

In this work the World Health Organization a United Nations agency, has played an important part by convening groups of experts from various countries to discuss specific public health problems From one of these expert committee sessions came a report on the place of the mental hospital in the community which has stimulated much progressive thinking (World Health Organization, 1953) In it the idea of the community mental hospital is set forth, and this new and total approach to mental illness is described

The community mental hospital breaks sharply with traditional nineteenth-century concepts of segregation and custodial care of the mentally ill In principle this approach has received warm acceptance by responsible mental health authorities in western Europe but this does not mean that old ways have been abandoned there, any more than in the United States, but, certainly, the spirit of the community mental hospital idea is influencing current planning Acute awareness of its implications are felt in England the Netherlands, Denmark and other countries and, in some of these firm steps in the direction of its real [illegible] has deve[illegible] in both practice and theory However, these concepts are new and still developing, and much is to be learned by the ways in which they are applied in various countries

THE AGED PATIENT

While the advantages of the community mental hospital and other advanced practices are not limited to any one age group, there is reason to believe that as a group the aged present sufficiently different problems to warrant special consideration No uniform approach to the care of the senile demented patient has yet appeared, although with increasing frequency the suggestion is encountered that special institutions be provided for them Interest is gathering in this area, and expectations for imaginative developments are not likely to be disappointed, but the moment of fruition has yet to arrive What these expectations are will be suggested in the following sections of this chapter if the future can be judged from current developments in western Europe Certainly, the time has arrived to give mental health problems of the aged serious and productive consideration

II FRANCE

There appears to be no aggressive attack directed at the specific mental health problems of the aged in France Considerable effort and attention are being given, however to the expansion and modernization of the mental hospital system and to the improvement of medical and social services to patients The over all plan for the betterment of mental health services and the rehabilitation of the hospital system has been formulated and in operation since 1953 In spite of persistent financial difficulties, considerable work has been carried out under this program New hospitals have been built, and others have been modernized and enlarged, but antiquated institutions are still the rule, and, by the advanced standards of space requirements per patient established by the Ministry of Health, overcrowding is common

Although no special efforts have been directed to the aged and senile patient, it is apparent that he presents an as yet unsolved problem to the mental health authorities in France just as he does in most other regions and countries The Ministry of Health (1953, 1956) planning reports, which are presented in some detail below, point out that older age groups are not overrepresented in the hospital population and, therefore, cannot be held responsible for the present crowded conditions of the hospitals There apparently is, however, a growing tendency to reduce the admission rate of aged patients by means of a more careful screening This trend is to be seen in other European countries, but unfortunately it is not always accompanied by a

clear cut policy covering the care and follow up of individuals so rejected

A The Organization of Mental Health Services

The Ministry of Health well recognizes that the treatment of mental disease is a many sided process Thus it is assumed that the complete mental health program begins with a case finding agency or clinical center which may also offer outpatient treatment. This is followed by a hospital system, with adequate provision for all necessary forms of specialized treatment and finally, a mental hygiene clinic to continue follow up and necessary psychiatric care for the released patient

MENTAL HOSPITALS

The mainstay of the mental health service of France is the psychiatric hospital in its various forms The present system is dated from 1838 when each department of France was required by law either to maintain its own psychiatric hospital or to arrange for the treatment of its mentally ill in a neighboring department or in an appropriate private institution As a result of this law in January, 1953, there were 90 such psychiatric hospitals, by 1957 these had increased to 101 Table 1 shows the number and capacity of these institutions in 1953 and their growth under the operation of the developmental plan instituted in 1953

With the exception of the hospitals built or remodeled since 1953, the typical French mental hospital is old and vitally in need of expansion and modernization As indicated in Table 1 there are four different types of institutions utilized by the various departments for the great majority of mental patients

TABLE 1*

INVENTORY OF BEDS FOR MENTAL PATIENTS IN FRANCE AS OF JANUARY 1953 AND UPON COMPLETION OF 5 YEAR PLAN†

Type of Institution	January 1953			Upon Completion of Plan		
	No	Optimum Bed Capacity	Maximum Bed Capacity	No	Optimum Bed Capacity	Maximum Bed Capacity
Autonomous hospitals	7	5 853	7 641	7	6 755	8 554
Departmental hospitals	52	35 009	45 724	61	45 323	56 238
Psychiatric quarters of general hospitals	11	4 435	5 790	13	5 192	7 108
Private psychiatric hospitals	20	13 903	18 062	20	14 638	19 071
Total for psychiatric hospitals	90	59 200	77 217	101	71 906	90 971
Neuropsychiatric services of general hospitals (40 per cent of total beds)			800			1 100
Private clinics	58		2 920			2 920
Total			80 937			94 991

* Source Ministry of Health, Plan d équipement sanitaire lutte contre les maladies mentales " Part I (Paris 1953) and "Deuxième plan d équipement 1958–61 hôpitaux psychiatriques Part I (Paris 1956) (Mimeographed)

† Does not include family colonies

1 *Autonomous psychiatric hospitals* These institutions founded centuries ago through gifts bequests and ancient ownership of land are able to operate independently of departmental supervision and are related administratively only to the central national authority Although no new hospitals have been added in this category some increase in capacity has been effected since 1953

2 *Departmental psychiatric hospitals* Sixty one departmental hospitals were in operation

in 1957 Eight of these were constructed under the 1953 plan and two additional ones not so financed were placed in service during this period. Since one hospital was closed during this same time the net increase was nine hospitals or over 10 000 beds in the years covered by the construction program

3 *Psychiatric sections or annexes of general hospitals* These have increased in capacity since 1953 but do not account for a major share of total capacity

4 [illegible]

tract ual agreemen [illegible]

way and a number of other departments used this arrangement to care for patients they were not able to place in their own institutions Although the increase in capacity of this type of institution was slight they remain an important source of hospitalization

FAMILY COLONIES OF THE MENTALLY ILL

At the close of the last century following principally the experience of Belgium and Scotland the Department of the Seine created in a village some miles from Paris a system of care for certain types of the mentally ill which permitted them to enjoy nearly normal community living under conditions of considerable liberty Though legally certified and technically under psychiatric hospital jurisdiction these patients are put under the care of private individuals living in the community who lodge and feed them in return for a per diem allowance provided by the state

The family colony as it is called is provided with a centralized medical service which is able to care for patients during periods when temporary hospitalization is required In addition visiting nurses keep the patients under surveillance

A number of advantages are claimed for the system Important among these is the almost total liberty it allows the patient and the fact that he may have gainful employment within the limits of his ability and under the supervision of the physician The therapeutic benefits derived from this regime and the relatively low cost of care have contributed to its apparent success

In practice, patients are not supposed to work for the family with whom they live but are usually employed by neighboring farmers to help with chores There is variety, however One woman patient has for a number of years given private English lessons to children, and another has carried out simple clerical duties in a small office Although a precise breakdown of the age of these patients is not available, many of them are in their fifties and sixties

Growth of the colonies has been steady but not spectacular Some years after the founding of the first colony a second was opened at Ainay le Château, about 25 miles from the original one at Dun At present the two colonies serve about 1800 patients of the Department of the Seine Although expansion of the colonies is anticipated none is reported during the period since 1953 Part of the difficulty with the project lies in the fact that it can serve effectively only a rather select group of patients They must be individuals who do not need a closely supervised therapeutic regime, who are not likely to be dangerous to themselves or others and who are willing to remain voluntarily in these communities located for the most part several hundred miles from their homes Because close care and supervision are not possible one authority felt that they were unsuitable for the aged patient, although perhaps very satisfactory for the aging physically healthy chronic cases who are otherwise qualified for such placement

Neuropsychiatric services of general hospitals —These services do not receive patients who are legally certified and committed as mentally ill It is estimated that about 40 per cent of the capacity of these units is devoted to the care of psychotic patients treated in open wards The remaining capacity is placed in the service of non psychotic individuals requiring treatment for various neurological disorders and for neurosurgery Since it would appear

that only about 700 or 800 beds in these services are utilized for the less severe mental illnesses, their contribution to the total resources is quite small

Private clinics.—Similarly, these institutions make only a small contribution to total mental health treatment resources. They serve primarily patients drawn from upper economic groups who prefer not to go to public institutions. Twelve of the 58 clinics or hospitals are permitted to take legally certified patients, but these account for almost half the beds in this category. Since there are somewhat fewer patients (*ca.* 2500) than beds, these institutions do not share the general overcrowding.

DETERMINATION OF THEORETICAL SPACE NORMS

It will be noted in Table 1 that both optimum and maximum bed capacity is given. In arriving at these figures, the actual number of beds as such was ignored and estimates were made upon the basis of theoretically determined space requirements per patient. When these norms had been determined, they were then applied to floor area available for patient use in existing institutions in order to fix both the optimum and the maximum capacity. These norms were also applied in the building of new hospitals, however, in this case it was insisted that only optimum standards be used.

In arriving at these norms, it was clearly recognized that mental illnesses are not "bed" illnesses. Mental patients do not necessarily live in the same rooms in which they sleep, and consequently they need more floor area than do patients of ordinary medical and surgical hospitals.

The Ministry of Health feels that so-called medical techniques, indispensable though they may be in certain instances, are insufficient in themselves to effect the restoration of the mental patient to the society which has already rejected him. Resocialization of the mentally ill can be fully accomplished only through the organization of the social life of the psychiatric hospital with this objective in view. Therefore, projected mental hospital plans for France must include, in addition to refectories and sleeping places, dayrooms where patients may meet together for recreation and for therapeutic work programs. These must be sufficiently numerous so that reasonably small and intimate patient groups may be formed.

In addition, it was held necessary that certain patients have rooms or cubicles for themselves. Ideally, about 25 per cent of the patients should be provided with this type of accommodation, and 5 per cent was taken to be the absolute minimum.

Applying these theoretical considerations to the space needs of fifty patients, the following estimates were obtained: (*a*) 12 rooms or cubicles of 108 square feet each, (*b*) 38 beds in a ward in groups of 3, 4, or 6, with 8 as an absolute maximum; this ward to cover a surface area of approximately 2450 square feet, or about 65 square feet per patient, (*c*) a dayroom for various purposes (meetings, lectures, occupational therapy, etc.) totaling an area about 2690 square feet, or about 54 square feet per patient, (*d*) a refectory, distinct from the dayroom, with an area of about 540 square feet.

Thus the total area deemed necessary for fifty patients is 7000 square feet, or about 140 square feet each. In providing for minimum standards, the dayroom area was diminished to 32 square feet per patient, and the individual rooms from 108 to 98 square feet for 5 per cent of all patients instead of 25 per cent (France, Ministry of Health, 1953, Part I). New construction is designed according to the optimum norms given above, with the exception that 98 square feet was accepted for the individual rooms because it was felt that at this reduced figure it would be impossible to introduce a second bed into the room and thereby destroy it for its intended purpose. The provision of these rooms for 25 per cent of the patients was retained.

CERTIFICATION AND COMMITMENT

Although certification and commitment procedures are still governed by the provisions of the law of June 30, 1838, long practice and familiarity with the system give it a flexibility that is not immediately apparent Until 1921 all admissions to mental hospitals were effected only through legal means However, in that year, the Hopital Henri Rousselle in Paris began admitting patients for treatment on a voluntary basis without certification The practice has grown since then

nomenon, for such overcrowding has been a chronic condition It is more than interesting to note that in 1940 more than 110 000 patients were being treated in psychiatric hospitals This number is greater than the patient population in 1955 Since considerable expansion and modernization had already been undertaken by the later date, it is obvious that great overcrowding was characteristic of the prewar years

The terrible conditions during World War II were responsible for the great drop

TABLE 2*

RATE OF GROWTH OF PSYCHIATRIC HOSPITAL POPULATION IN FRANCE 1946–55

Year	Population of France (in Millions)	Population under Treatment in Psychiatric Hospitals	Rate of Hospitalization per 1000 Population	Admissions (First Admissions Transfers and Readmissions)
1946	40 2	65 623	1 63	
1947	40 7	67 972	1 66	
1948	41 2	75 315	1 82	
1949	41 6	80 095	1 92	
1950	41 9	85 659	2 04	
1951	42 2	92 496	2 19	
1952	42 1	97 000	2 30	54 076
1953	42 4	100 141	2 36	57 711
1954	42 7	103 409	2 42	59 896
1955	43 0	105 492	2 45	63 520

*Source Ministry of Health, Plan d equipement sanitaire lutte contre les maladies mentales" Part II (Paris 1953 and Deuxième plan d équipement 1958–61 hôpitaux psychiatriques, Part II Paris 1956) (Mimeographed)

Under the legal provisions two kinds of commitments are possible The first is voluntary in name only and refers to a procedure whereby the family of the patients seeks and obtains the hospitalization for him The second is involuntary in the sense that the prefect of the department or in Paris the prefect of police may order the hospitalization of persons thought to be a public menace by reason of mental illness

OVERCROWDING IN MENTAL HOSPITALS

A comparison of Tables 1 and 2 shows clearly the extent of overcrowding in French mental hospitals This apparently is not simply a post–World War II phe

in the number of patients between 1940 and 1946 Deaths from hunger and cold reduced the patient population by thousands Hunger was not the exclusive lot of the patients The medical director of one large hospital in Paris tells of fainting from hunger three times in the streets during this time of deprivation Reduced consumption of alcohol may also have contributed to some extent to the lessening of the patient load during this time Certainly, the reluctance of families to send mentally ill members to hospitals where conditions were known to be difficult prevented the replacement of patients lost through death and discharge

An analogous situation occurred during and after World War I Then depopulation of the mental hospitals could be largely attributed to the influenza epidemic which occurred during the late years of the war In 1920 there were 64 888 patients under treatment in the mental hospitals In the ensuing years the population increased as follows

1921	66 497	1925	75 580
1922	68 912	1926	77 013
1923	71 052	1931	88 427
1924	73 151	1939	103 30"

CAUSES OF ACCELERATED GROWTH OF MENTAL HOSPITAL POPULATION

It has been popular in France to attribute the rapid increase in the number of mental patients to increased incidence of alcoholism and to disproportionate representation of the aged in the hospital population *The Ministry of Health feels* however that neither of these factors is at present responsible for the overcrowding to any great extent Although alcoholism and psychoses with alcoholism account for a high percentage of admissions (9 44 per cent of all female admissions and 40 93 per cent of male admissions in 1955) only a relatively small percentage of the total number of days of hospitalization can be attributed to this cause (6 per cent in 1954 for both sexes combined) because of the high discharge rate Since the aged are represented in the hospital population in almost exact*ly the same percentage as their occurrence* in the national population this source of crowding is also largely discounted More will be said on this point below

The factors held mainly responsible for the increase are as follows

1 *Improvement of case finding services* Such services did not exist to any great extent before the war Early case finding which leads to early cure and release has caused a notable increase in the number of patients under treatment particularly voluntary and outpatients

2 *Changes in public attitude* Greater public understanding of mental illness has resulted in increased acceptance of treatment and to a lessening of prejudice against mental hospitals This acceptance has been aided by the development of the newer therapies

3 *Increased scope of treatment* Demand for psychiatric treatment for mental disturbances such as personality disorders perversions etc which were never before hospitalized in France has led to a perceptible increase in demand for beds particularly for patients who exhibit antisocial behavior and whose conditions are often medicolegal in nature

the home At another time this would have been commonplace

5 *Growth of French population* This factor in combination with others listed here quite naturally increases the number of mental patients

6 *Reduction in mortality rate* Although the number of patients released as cured or improved during their first year of treatment has increased and the mean duration of stay of these patients has decreased a dramatic decrease in mortality rate since the war has to a large extent prevented a reduction in total patient population

The figures used to support the last of the above items are most interesting A study of the mean duration of stay of patients in eleven psychiatric hospitals showed that the proportion of patients released as cured or improved within a year of admission increased from 34 3 per cent of all admissions in 1934 to 42 5 per cent in 1946 and at the same time the mean *duration of* stay for these patients decreased from 136 days to 95 days Furthermore the percentage of those released cured or improved after a period of *over* a year increased from 8 2 in 1934 to 9 5 in 1946 Similarly study of another group of psychiatric hospitals showed that in 1951 *39 8 per cent of patients* admitted during that year were released as cured or improved during the same year

Opposed to these trends toward lessening hospital population is the evident decrease in mortality In 1934 in the eleven hospitals mentioned above *36 per cent of the* patients present on January 1 plus those

admitted during the period died within a year In 1946 this had been reduced to 16 9 per cent and by 1951 it was *only 4.3 per cent* This reduction in mortality rate was as might be expected related to an increase in the number of days of hospitalization for those patients who do die in the hospital This marked reduction in mortality is attributed to progress in general medical therapeutics The net effect tends to increase the hospital population (France Ministry of Health 1953 1956)

B Causes of Diminution of Annual Increment in Hospital Population

Inspection of Table 2 shows that the psychiatric hospital population exhibited an annual increment of about 5000 patients for the period 1946–52 but for the period 1952 55 this increase appears to be no more than 3000 per year This slackening of net increase cannot be attributed to any lessening of morbidity for it can be seen that admissions actually rose during this period

Several reasons are advanced by the Ministry of Health to account for the lessening of the annual increase in population in the face of the increased demand for service from the mental hospitals Principally these are the utilization of new medical therapies and improvement of operating conditions of the mental hospitals For several years an active program designed to effect this improvement has been under way These measures have been directed mainly at improving and augmenting the physical *equipment* of the hospitals and particularly to increasing the number of medical and *other* personnel Specifically with reference to the latter factor the following developments have taken place

Psychiatrists (médecins chefs) In 1952 only 194 psychiatrists were employed

to all French hospitals equ

Interns (internes) While these are apparently training positions they greatly augment available medical services It is intended that each medical service shall have at least two of these posts They have increased in number from 250 in 1952 to about 400 by October 1956

Social workers (assistantes sociales) In 1952 only a few hospitals had social workers attached to their staffs The number is growing however and by 1956 most hospitals were able to have at least one worker

Medical secretaries By relieving physicians

of the hospitals had medical secretaries

Nursing personnel Shortages have been felt in this area In 1952 there was not more than one nurse to every twenty five patients At the end of that year a recruiting campaign was instituted which proved very effective in some hospitals but scarcely altered the situation in others It is safe to say that a shortage still exists

Other factors have also served to ameliorate the progressive growth of psychiatric hospital population These include the introduction of medical techniques (use of electroencephalograms laboratories etc.) as well as activity programs for patients (occupational therapy, recreational activities etc) Improvements in food and clothing and in living conditions in general have also done much to improve the atmosphere of the hospital and to facilitate the readjustment of the patient

This program of active treatment and social rehabilitation has been demonstrably effective In Ville Evrard on the outskirts of Paris the average stay of *discharged patients in 1948* was over a year by 1956 it had been reduced to 4 *months* At the beginning of the experimental period the hospital had 550 patients and admitted 100 new patients a year By 1956 the number of beds had been reduced to 270 but the hospital gave care to 600 new patients a year Furthermore the *proportion* of patients being kept indefinitely in the hospital was reduced from 50 to 7 per cent (World Health Organization 1957*b*)

C. The Aged Patient

In 1952 the Ministry of Health conducted a study of the aged in psychiatric hospitals in order to examine possibilities of transferring some of them to hospices. The results of this inquiry are presented in Table 3

From this table it will be noted that during the year under investigation a total of 35,521 patients (not including outpatients and those under age 18) were admitted to French psychiatric hospitals Of these, 5479 patients were age 65 or older, representing 15 3 per cent of the total admissions for the year

We note further that 41 6 per cent of the patients admitted under the age of 65 are released as cured or improved during the same year For patients in the 66–75 age group this percentage is still relatively high (i e, approximately 26 per cent) However, for patients over age 75 the proportion released cured or improved is only 13 per cent of the admissions

From these figures it is evident that, although the chances of early cure or improvement decrease with age, they are still sufficiently high in the 66–75 age group to be encouraging It is considerably less so for the older patients Nevertheless, when one takes into account the total number of patients leaving the hospital for all reasons during the year of their admission—for improvement in health, transfer to hospice, and death—it becomes apparent that an almost equal proportion of each age group remains in the hospital at the end of the year. The reason for this is, of course, the higher mortality rate of the older patients

For this reason it is felt that the older age groups do not overcontribute to the swelling of the total mental hospital population There is, however, other evidence to support this contention

If the proportion of the aged in the mental hospitals is compared with the proportion of the aged in the total population, remarkable similarity between the two figures is found Thus the proportion of patients over age 65 in the psychiatric hospitals on June 1, 1952, in relation to the total hospital population over age 18 was established as 16 4 per cent The same calculation made for the entire population of France for January 1, 1953 yields a per-

TABLE 3*

PSYCHIATRIC HOSPITAL POPULATION OF FRANCE, BY AGE

	18 65 Years			66–75 Years			Over 75 Years			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
1 No of patients admitted in 1951	15,294	14,748	30,042	1215	2223	3438	604	1437	2041	17,113	18,408	35,521
2 No admitted and released in same year (1951)												
a) Cured or improved	6,196	6,318	12,514	363	529	892	103	163	266	6,662	7,010	13,672
b) Placed in hospice	238	171	409	59	51	110	24	48	72	321	270	591
c) Deceased	384	353	737	204	281	485	207	247	454	795	881	1,676
3 No patients in treatment, June 1, 1952	33,168	38,654	71,822	2982	6914	9896	898	3266	4164	37,018	48,834	85,882
4 No of above (3) likely to be placed in hospice	508	894	1 402	274	840	1114	145	470	615	927	2,204	3,131
5 Deceased during 1951	1,132	1,006	2,138	508	882	1390	420	1055	1475	2,060	2,943	5,003

* Source Ministry of Health, Plan d équipement sanitaire lutte contre les maladies mentales Part II (Paris 1953) (Mimeographed)

ntage of 16 02 While this proportion may vary from institution to institution, it is quite obvious that the proportion of the aged in the mental hospitals is almost identical to their proportion in the total French population

As the proportion of aged in the total population increases, it appears that the proportion in the mental hospitals keeps pace In 1954, 17 4 per cent of the adult population of France (not including children under 18 years) was over age 65 The same age group comprised 17 76 per cent of the adult mental hospital population during this year

1 *Decrease in admission rate for aged* — It is significant to note however, that, in spite of this slight increase in the number of aged in the mental hospitals a noticeable drop is detected during this period in the *admission rates* of the aged In 1951 we see that 15 3 per cent of the total admissions over 18 years of age were aged 65 or older (Table 3) By 1954 this figure had been reduced to 12 53 per cent It is felt that this diminution may be directly attributed to the adoption of a more vigorous screening program aimed at denying admission to those aged patients who can not be aided by psychiatric therapy

This tendency is to be seen elsewhere notably in Italy but what remains as yet unclear is the final disposition of these cases Certainly in the broad sense they remain mental health problems and cannot be dismissed as such simply because they do not qualify for hospitalization on purely medical and psychiatric grounds

2 *Sex differences* —The close parallel between the proportion of the aged in the national population and the hospital population does not hold if the statistics are analyzed by sex This may be seen from Table 4

Thus it is evident that the mental hospitals have a somewhat larger number of aged females and a slightly smaller number of males than would be expected from the proportion of these age groups in the general population. There is some evidence to believe that the proportion of hospitalized females is increasing while the proportion of aged men remains about the same This phenomenon, however, seems also to apply to the sex ratio for patients between the ages of 18 and 65

On June 1, 1952, there were 37,048 male patients in the mental hospitals of France and 48 834 female patients In 1951, however, the number of adult female admissions hardly exceeded male admissions [illegible] difference [illegible] of a

Nor is the explanation likely to be found in sex differences in responsiveness to treatment When we consider the number of patients admitted and released during the same year in relation to total admissions, no important differences between men and women can be found

TABLE 4

PERCENTAGE OVER AGE 65 IN ADULT POPULATION AND ADULT MENTAL HOSPITAL POPULATION FRANCE BY SEX

	Percentage over 65	
	Women	Men
Adult population of France	18 6	13 4
Adult mental hospital population	20 8	10 5

The probable explanation lies in the fact of the higher male death rate, particularly in the later years, as can be seen from the figures given in Table 5 Thus it appears that the prolongation of life through improved medical care and more favorable living conditions coupled with the lower female death rate may be the major factors contributing to the overrepresentation of women in the mental hospitals

3 *Proposals to meet problems of aged patient* —Any of the plans and proposals now under way to improve the care of the mentally ill in France will benefit all age groups The most important steps have al

ready been initiated, and these are directed at alleviating the painful overcrowding which besets so many hospitals.

In recent years it has not been rare for some hospital populations to equal 150–200 per cent of the estimated capacity. Thus the Marchant Hospital at Toulouse with a maximum capacity of 373 beds had 554 patients under treatment on June 15, 1955. On the same date the Maison Blanche, a hospital of the Department of the Seine, had 3066 patients for a maximum capacity of 1969 places.

Such crowding means that every available space must be used to accommodate patients. Beds may be placed in refectories,

TABLE 5

MORTALITY RATE OF MENTAL HOSPITAL PATIENTS, FRANCE, BY AGE AND SEX

PATIENTS' AGE GROUP	MORTALITY RATE (PER CENT)	
	Male	Female
18–65	2.5	2.3
65–75	16.7	14.8
Over 75	34.2	17.1

dayrooms, and corridors and on stair landings, while in the wards the space alloted for each bed is an irreducible minimum. France is not unique in this condition, for many parallels can be found in the United States and elsewhere.

To improve this situation, much renovation of physical plant is essential. Modernization of sanitary equipment, heating plant (some hospitals did not have central heating as late as 1958), kitchens, and laundries is being provided for in plans already under way. These improvements are deemed absolutely essential if patients are to receive effective treatment. Only in this way, it is felt, can an adequate mental health service dedicated to cure rather than to custodial care of patients be established.

In making its recommendations, the Ministry of Health utilizes the ratio of mental hospital beds to total national population set up by the Expert Committee on Mental Health of the World Health Organization (1953). This ratio of 3 beds for each 1000 of the national population means that by 1961 France should have 134,400 beds. This figure is based upon an estimated total population of 44 800 000 for the year 1961. In presenting its argument, the Ministry indicates that in 1953 England and Wales already had a ratio of 3.7 beds per 1000 population and that the ratio in Switzerland had already reached 4 beds per 1000. In the United States during the same year, of 41 states reporting, 9 had fewer beds than required by the WHO ratio, but the remainder ranged up to twice the recommended number, with New York, the most populous state, leading with 6.36 beds per 1000 patients (U.S. Congress, 1957*a*).

If the estimated need of 134 400 beds is accepted, reference to Table 1 shows that by 1961 France will still need more than 40 000 additional beds to accommodate adequately its mental hospital population even after the completion of its first plan of construction and modernization. This figure is based upon maximum capacity estimates. In order to give each patient the optimum amount of space, over 62 000 beds would have to be provided in addition to those available at the completion of the first plan.

In comparing the French estimate of its own hospital needs with the actual statistics of other countries, great care must be taken. It will be remembered that the French Ministry of Health draws a clear distinction between the number of patients and the number of beds. Elsewhere this distinction is not commonly made. Thus France is literally providing beds for a far larger number of patients than either the optimum or the maximum capacities of her mental hospitals are estimated to have.

It is properly recognized that, urgent as is the need for additional hospital space, the answer to overcrowding is not simply to provide more beds. With this in mind,

an entire mental health program is envisioned one part of which has direct reference to the problem of the aged and others have at least indirect bearing Briefly these proposals and recommendations are

1 Improvement of living conditions in the hospitals to provide an atmosphere in which modern therapeutic methods can be most effective
2 Organization of a program aimed at preventing alcoholism and for the outpatient care of alcoholics (That the first part of this campaign at least is under way is evident from the many posters one sees in Paris urging moderation in drink)
3 [illegible]

related to the hospital
4 The development of mental hygiene consultation services in order to permit the early release of patients to the care of these services
5 The extension of family colonies and the creation of family placement services not only for convalescing patients but also for [illegible]

number of years

III The Netherlands

The Netherlands is a small country with a population about one quarter that of France yet it would be singularly inappropriate to refer to it as a tiny country Highly industrialized its ports are among the busiest in the world A progressive country its compact size and predominant urban character as well as traditional patterns of social organization have left their imprint upon the nation s developing approach toward its mental health problem In this its methods are advanced and effective and many are beyond the experimental stage This does not mean that planning and implementation are complete but rather that developmental directions are clearly indicated

A Patient Population

[illegible] of the [illegible]al hos[illegible] From Table 6 we note that the total number of patients is just over 33 000 Since the estimated national population in December, 1956 was 10 957,040 it is apparent that there are about 3 mental hospital patients for each 1000 persons living in the Netherlands This it will be recalled is the normal ratio for western European countries adopted by the WHO Expert Committee (World Health Organization, 1953)

Unlike France the total mental hospital population is quite evenly divided between the sexes, with a very slight predominance of male patients In this ratio the sex composition of the total Dutch population is reasonably well reproduced although in actual fact there are slightly more females than males in the nation (50 2 per cent females and 49 8 per cent males)

A marked shift in the sex ratio occurs however in patients aged 60 and older Here once again is seen a relatively high proportion of women with approximately five female patients for every four males The situation is almost the exact reverse with patients under age 60, among whom there are approximately six men for every five women

The disparity in numbers between older men and women cannot be attributed to differences in first admission rates, for in Table 7 it may be seen that the rate for men aged 60 and above is actually greater than that of women While an almost equal number of male and female patients are admitted annually, this ratio is not maintained consistently over the entire age range Thus more males are admitted under the age of 40 but in the age group 40–59 years the number of female admissions substantially exceeds that of males

Table 8 suggests that a partial duplication of the French experience may account for the larger number of female patients in the aged group Here we see that even

though more older women than men are released from the mental hospitals this factor is more than compensated for by the higher male death rate in this age group While this may not be the complete explanation for the preponderance of aged women patients it is one which readily commends itself and is supported by experience elsewhere

From Table 7 it can be seen that 16 6 per cent of all first admissions come from the age group 70 years and older These figures when compared to the percentage of this age group in the total population indicate to some extent the overrepresentation of the aged among the hospitalized mentally ill Thus in December, 1956 only 5 0 per cent of the male population was aged 70 and above and only 5 6 per cent of the female population fell within this age group Both sexes together, aged 70 and older, comprise 5 3 per cent of the population This age group is therefore admitted to Dutch mental hospitals at approximately three times the rate which would be expected from its proportion in the total population Since not all of the mentally ill reach psychiatric institutions admission figures and hospital population statistics are conservative estimates of both the extent of mental illness and the contribution of older age groups to the nation s mental ill health

B Certification and Commitment

The great majority of mental patients in the Netherlands enter the hospital volun

TABLE 6*

MENTAL HOSPITAL POPULATION OF THE NETHERLANDS BY AGE AND SEX

Age	Men		Women		Total	
	No	Per Cent	No	Per Cent	No	Per Cent
Under 60	12 740	54 0	10 843	46 0	23 583	100
60 and over	4 378	45 2	5 315	54 8	9 693	100
All ages	17 118	51 4	16 158	48 6	33 276	100

* Source *Medical Ch f In pe n fo Men l Hea h* The Hague Jan a y 1 1957

TABLE 7*

FIRST ADMISSIONS TO MENTAL HOSPITALS IN THE NETHERLANDS BY AGE AND SEX

Age Group	Men		Women		Total	
	No	Per Cent	No	Per Cent	No	Per Cent
0 14	289	6 4	167	3 9	456	5 2
15-34	1 09	38 1	1457	34 3	3166	36 2
40-59	1251	2 9	1482	34 9	2733	31 3
60-69	464	10 3	466	11 0	930	10 6
70 and older	776	17 3	678	15 9	1454	16 6
Under 60	3243	51 1	3106	48 9	6355	100
60 and older	1240	52 0	1144	48 0	2384	100
Total	4483	51 4	4250	48 6	8733	100

* Sou e M I h f In pe ion M a I h Hel J 1 9

tarily for treatment. In Amsterdam, because of its highly effective program of social psychiatric service, which will be described in detail below, the proportion of involuntary or certified patients is approximately 5 per cent of the total admissions (Querido 1948–49) Elsewhere in the country the proportion is greater, but involuntary admissions do not exceed 25 per cent of total admissions

Under certain circumstances a patient may be placed under observation for a period not longer than 6 weeks in order to determine the advisability of committing to hospital This provision is rarely used It is estimated in Amsterdam that perhaps thirty patients a year are treated in this manner

Release from the hospital is generally readily obtained and is encouraged as soon as it is thought the patient will be able to adjust to home and community life Readmission rates consequently tend to be high accounting for about 20–25 per cent of the total annual admissions

Dr A Querido professor of social medicine and director of Amsterdam s Central Office for Public Health explains that hospitalization is presented to the mentally ill patient exactly as it is presented to patients with somatic illnesses requiring extensive hospital treatment His condition is discussed with him honestly, and the need for hospitalization is thoroughly explained In some instances the patient is encouraged to go to the hospital so that he can see for himself the kind of place it is This approach to the patient is but part of a total pattern of social treatment designed to effect the patient s early return to society as a useful and well person It has drastically reduced the necessity of resorting to compulsion in order to provide treatment for the mentally ill

C *Admission of Senile Patients*

In Amsterdam aged patients who are mentally disturbed are admitted first into a segregated geriatric ward of a general hospital Here their care and treatment are under the direction of an internist rather than a psychiatrist, and the first objective is to treat any aberrant physical conditions which may present themselves Experience

TABLE 8*

RELEASE AND MORTALITY RATE OF MENTAL HOSPITALS IN THE NETHERLANDS

Age	Men		Women		Total	
	No	Per Cent	No	Per Cent	No	Per Cent
Released during year						
Under 60	2781	50 5	2720	49 5	5501	100
60 and over	558	47 1	627	52 9	1185	100
Total released	3339	49 1	3347	50 1	6686	100
Died during year						
Under 60	241	55 9	190	44 1	431	100
60 and over	9 0	54 1	824	45 9	1794	100
Total deaths	1211	54 4	1014	45 6	2225	100
Releases plus deaths						
Under 60	3022	50 9	2910	49 1	5932	100
60 and over	1548	51 3	1451	48 7	29 9	100
Total releases plus deaths	4550	51 0	4361	49 0	8911	100

* Source *Medical Ch* (Direction for Mental Health (The Hague January 1 19 7)

has shown that the correction of physical dysfunction in these cases frequently results in a remission of mental symptoms.

Only a relatively small percentage of these patients are ultimately sent to the mental hospital and these are usually seriously disturbed organic cases. Of the remainder, about one third are able to return home after treatment in the geriatric ward, one third are sent to nursing homes for care, and about one third die within 8 months of admission. The usual reluctance of the general hospital in accepting senile cases has largely disappeared because patients are not deposited in their wards for indefinite periods utilizing space that could more usefully be given to acute cases. Knowledge that the hospital is functioning as part of an integrated plan which enjoins inaction and indeterminate stay has opened general hospital doors to the senile patient.

EARLY DIAGNOSIS AND SOCIAL TREATMENT

Much of what is best in the mental health services in the Netherlands can be illustrated by the operation of the Department of Mental Hygiene in Amsterdam. While this service originated in attempts to meet the demands which pressing medical needs were making upon badly strained resources following World War I, subsequent success of the empirical measures taken then has led to the establishment of a basic, underlying theory which supports the general applicability of the approach (Querido 1948, 1948–49).

ORIGINS

Early in the 1920's the city of Amsterdam adopted a centralized system of assigning patients to hospital. This action received the full co-operation of the city's medical practitioners because shortage of hospital beds not only was creating a delay in the treatment of patients but was forcing the physician to expend a considerable portion of his time searching for vacant beds and making necessary arrangements. Although this centralized system applied only to patients who could not pay for full hospitalization, its effects were widespread since about 90 per cent of all patients needed assistance in the payment of fees.

The centralized system was never a simple clerical operation but was integrated into the newly established Medical and Health Department of the city. Doctors were assigned to this service and were always on duty not only to assist with the requests for hospitalization but also to operate an emergency first aid service.

From the very beginning a psychiatrist was attached to the service in an advisory capacity. His principal function was to help in the assignment of patients to the city's four hundred psychiatric beds or to mental hospitals elsewhere in the country with which the city maintained contractual arrangements.

Gradually this function extended until it became established as the Department of Mental Hygiene with a very active role in the community's mental health services. Its principal functions were twofold: (1) assisting and supervising the "socially unfit" (chronic mild psychotics, older mental defectives, and others needing permanent nursing and supervision) to function to the best of their capacity in the community, and (2) maintaining a program of preventive care for patients who might otherwise be hospitalized and supervising the post-care of former mental patients.

PSYCHIATRIC FIRST AID

With the consolidation of these two functions and with the necessary increase in psychiatric and social personnel to carry them out adequately, a new and unique service began to develop. This has been called "psychiatric first aid." While not a wholly appropriate term, it does emphasize the most important feature of the service, that is, at the first sign of mental disturbance, or of "peculiar behavior," the Department of Mental Hygiene is called and the psychiatrist on duty responds not simply with advice, but with his presence at the scene of the incident.

The latter point is most significant The patient is not taken to the hospital or observation ward (or, indeed, the *police station*), where he is examined in *private and* in isolation by the physician *Rather the psychiatrist* sees him where the precipitating *episode* occurred The physician is able to see members of the family or other participants in the social crisis almost at *the time of* its occurrence and in the social and physical setting in which it took place

After examination the psychiatrist may *decide that* hospitalization is best for the patient but experience has shown abundantly that many cases once considered impossible to handle without hospitalization can with appropriate social psychiatric direction be treated best *at home* Careful reception and observation of new patients in the mental hospital or psychiatric ward are standard procedures in many states and countries but as Professor Querido points out the purpose of such procedures is to determine how best the *hospital* can serve the patient The principle inherent in psychiatric first aid is however the determination of the course of treatment best for the patient. Thus while hospitalization *may* ultimately be chosen as the best alternative for the patient it is only one of several available methods of treatment

Social psychiatric *case* histories are kept on all patients contacted and treated by the department Approximately 50 000 of these are in a file which is consulted routinely by the psychiatrist on duty before he responds to a call *Often* with this assistance he *is* able to approach the disturbed *individual* fully *briefed* about past episodes and treatment so that decisions can be made quickly and intelligently

Favorable past experience with this service has led *to its ready* acceptance, consequently emergency *calls for* service may originate from many sources The physician may feel the need for consultation and advice concerning his patient, or *the family* of the disturbed person may call directly in time of need The police have learned to depend upon the *services of the De*partment of Mental Hygiene and in certain cases *are required* to seek its aid Thus the psychiatrist is called in immediately if *mental* unbalance is suspected if a sex offense is involved and, *of particular interest* to this discussion, in *all cases where the offender is above the age of 70* This co operation has the obvious advantage of relieving the police of responsibility for medical decisions Since the psychiatrist's decision may contraindicate arrest and detention, respect for and understanding of his approach and recommendations by the police are essential

Years of successful operation of this system has gradually led *to* the centralization of information about *Amsterdam's* mental ly *disturbed* Housing authorities public assistance workers, as well as the Labor Exchange Office refer cases of suspected mental aberration to the Department of Mental Hygiene for attention in the knowledge that appropriate action will be forthcoming Psychiatrists in private *practice* welcome this assistance, because most of them received part of their training *in* the *department* and understand its aims and methods

Concern with the problems of the senile [illegible]

[illegible] which has far reaching *activities* covering such varied problems as emotionally disturbed and mentally defective children industrial mental hygiene, and even venereal disease it is an area in which *active* planning and development are taking place

The numerical extent of this interest can be *gauged by looking at* the program of patient home supervision operated by *the* department Individuals cared for under this program are persons who would otherwise be [illegible]

[illegible] with their families or independently Some of these are patients *released* from mental hospitals to the home supervisory care, others are cases for whom hospitalization had been re

quested but not carried out. These patients are not, strictly speaking, under medical treatment, but they do receive regular visits from the psychiatrist or the psychiatric social worker. The family is taught to live together, and social assistance of various sorts is given if indicated.

Amsterdam, a city of close to one million in population (870,000 in 1956), has 3000 of these patients under home supervisory care. When this number is added to the 2500 patients in mental hospitals (1958), a potential hospitalization rate of about 5.5–6 mental patients for each 1000 residents is obtained. This approximates the rate of New York State, which is the highest in the United States. The savings in hospital space and operating costs of this program are made obvious by these figures.

About 20 per cent of the patients under home supervision (about 600) are senile and mentally frail aged people. Some of these are placed in small nursing homes where some form of occupational therapy may be available for them. The great majority of these homes are privately operated, and the Mental Hygiene Department is not entirely satisfied with the quality of care they are able to offer. Certainly it is felt that these homes are insufficient in number.

1. *Plans for care of aged mental patients.*—Senile psychotic patients are at present crowding Dutch mental hospitals and are compromising the effectiveness of these institutions in treating acute cases in need of intensive therapy. Amsterdam is, therefore, in the process of constructing four nursing homes, each with a capacity of 150 beds, designed to provide a high quality of care suited to the needs of these patients. These will not necessarily increase Amsterdam's total nursing home bed capacity by the full 600 beds, because some of this capacity will undoubtedly replace a proportion of the existing 2000 beds now in use in the city.

Each of the proposed nursing homes is to be located in a populous central area of the city near a general hospital which will serve the medical needs of the residents. The 150 patients will be housed in five similar units designed to accommodate 30 patients in four rooms, each with a maximum of 8 patients. Every unit will have two adjoining recreation rooms, and a garden is considered as essential for each home. In addition, the homes will have a central room for physical therapy, one for occupational therapy, and a large recreation room where all residents may congregate. Some staff living quarters will be provided, but these will be kept to a minimum.

The staff envisioned for these homes include five fully qualified nurses assisted by thirty less fully trained individuals. In addition, there will be two physical therapists, one occupational therapist, and a physician to attend to the medical needs of residents on a part-time basis. One of the nurses would be in charge of operating the home. In her selection, factors of personality and attitude will be given fully as much consideration as professional qualifications.

Amsterdam is not alone in its planning and construction of nursing homes. Dr. P. Piebenga, chief inspector for mental health for the Netherlands, estimates that there is a national need for about 7500 such beds. Consequently, plans are under way for the construction of 50 homes each with a capacity of 150 beds. Work on this program has barely begun, and an early completion is not anticipated.

2. *A comprehensive program: consultation centers.*—Important though it is, the construction of nursing homes is but one facet of the Amsterdam program. Equally significant is the establishment of specialized consultation centers for old people. One of these centers is already in existence and a minimum of three more is planned. Full development of the program, however, awaits the construction of the nursing homes, for reasons which will become apparent below.

As indicated in Figure 1, the consultation service is in reality the center about which the entire program revolves. Here is the place toward which the aged in need

of help and advice turn when problems arise Through this center social, medical and psychiatric assistance is made available and through its efforts the entire resources available in the city are brought to bear efficiently and expeditiously upon each person's difficulty

It is interesting to note that in this scheme the mental hospital as such is not mentioned The reason for this can be inferred from the Dutch position that the great majority of the aged mentally ill should be cared for outside the mental hospitals thus freeing these institutions of much of their custodial obligations and allowing them to devote their energies more fully to the treatment of acute psychotic cases This does not mean that the senile patient is subject to psychiatric neglect but rather that because of the relatively large numbers of these patients and their peculiar needs they are better served in specialized settings

Reference to Figure 1 shows that the aged person receiving consultation services can be assisted through a variety of channels The consultation center itself may offer valuable support assistance, and advice Help may be extended in many ways— ... it of a mysterious (yet simple) governmental form to advice on personal problems A major objective of the center is to attract as many of the aged as possible to use its services casually, so that the good rapport thus established will enable the center to come to early assistance as more serious threats to the mental and physical well being of the individual arise

Should a mental or emotional crisis occur, arrangements would be made for the individual to enter the observation ward of the general hospital, where proper treatment would be instituted and appropriate disposition of the case be studied If rehabilitation is indicated, as in the case of stroke, accidental injury, crippling of the joints etc , the patient may be sent to the rehabilitation hospital for treatment and training From here he may be able to return to his home and perhaps be maintained there under some supervision, or placement in one of the available nursing homes may be necessary

The nursing home is indeed a key feature in this system It is first a guaranty to the various treatment facilities that acceptance of an aged patient does not carry with it the obligation for long term care, for such care will be undertaken by these institu

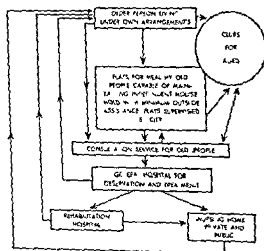


Fig 1—The Amsterdam plan for a community wide approach to the alleviation of mental health problems of the aged.

quested but not carried out. These patients are not strictly speaking under medical treatment, but they do receive regular visits from the psychiatrist or the psychiatric social worker. The family is taught to live together, and social assistance of various sorts is given if indicated.

Amsterdam, a city of close to one million in population (870,000 in 1956), has 1700 of these patients under home supervisory care. When this number is added to the 2500 patients in mental hospital (1956), a potential hospitalization rate of about 4.5–6 mental patients to each 1000 residents is obtained. This approximates the rate of New York State, which is the highest in the United States. The savings in hospital space and operating cost of this program are made obvious by these figures.

About 20 per cent of the patients under home supervision (about 600) are senile and mentally ill aged people. Some of these are placed in small nursing homes where some form of occupational therapy may be available for them. The great majority of these homes are privately operated, and the Mental Hygiene Department is not entirely satisfied with the quality of care they are able to offer. Certainly it is felt that these homes are insufficient in number.

1. *Plans for care of aged mental patients.*—Senile psychotic patients are at present crowding Dutch mental hospitals and are compromising the effectiveness of these institutions in treating acute cases in need of intensive therapy. Amsterdam is, therefore, in the process of constructing six nursing homes, each with a capacity of 150 beds, designed to provide a high quality of care suited to the needs of these patients. These will not necessarily increase Amsterdam's total nursing-home bed capacity by the full 900 beds, because some of this capacity will undoubtedly replace a proportion of the existing 2000 beds now in use in the city.

Each of the proposed nursing homes is to be located in a populous central area of the city near a general hospital which will serve the medical needs of the residents. The 150 patients will be housed in five smaller units designed to accommodate 30 patients in four rooms, each with a maximum of 8 patients. Every unit will have two small recreation rooms, and a garden is considered as essential for each home. In addition, the homes will have a central room for physical therapy, one for occupational therapy, and a large recreation room where all residents may congregate. Some staff living quarters will be provided, but these will be kept to a minimum.

The staff envisioned for these homes includes five fully qualified nurses assisted by thirty less fully trained individuals. In addition, there will be two physical therapists, one occupational therapist, and a physician to attend to the medical needs of residents on a part-time basis. One of the nurses would be in charge of operating the home. In her selection, factors of personality and attitude will be given fully as much consideration as professional qualifications.

Amsterdam is not alone in its planning and construction of nursing homes. Dr. F. Dijkema, chief inspector for mental health for the Netherlands, estimates that there is a national need for about 7500 such beds. Consequently plans are under way for the construction of 50 homes each with a capacity of 150 beds. Work on this program has barely begun, and an early completion is not anticipated.

2. *A comprehensive network of consultation centers.*—Important though it is, the construction of nursing homes is but one aspect of the Amsterdam program. Equally significant is the establishment of specialized consultation centers for old people. One of these centers is already in existence, and a minimum of three more is planned. Full development of the program, however, awaits the construction of the nursing homes, for reasons which will become apparent below.

As indicated in Figure 1, the consultation service is in reality the center about which the entire program revolves. Here is the place toward which the aged in need

atric hospitals is 1 to 7 or 8 Hopes are expressed that this can be reduced to 1 to 3½ or 1 to 4 For purposes of comparison it is interesting to recall that this ratio in French hospitals in 1952 was approximately 1 to 25

E The Mental Hospital Annex

The provision of specialized services for the aged mental patient is not being held in abeyance while awaiting the completion of the national program for nursing homes An example of what is being done is provided by Rotterdam s mental hospital at Poortugaal This hospital in recent years was able to acquire a little used quarantine station located some miles from the main hospital on Rotterdam s busy harbor Here was established an annex for about 50 male and 50 female patients

Direction of the annex remains in the hospital s hands and medical service is provided by a hospital physician who visits the annex daily The local operations and program are under the direction of a nurse in charge In spite of the distance meals are prepared in the kitchen of the main hospital and transported by truck to the annex

The annex buildings are well situated on the busy harbor and are of low construction Separate wings are provided for men and women Both sections contain several large common rooms where patients engage in various forms of occupational therapy Surrounding the buildings are grounds which may be used by the patients under supervision during summer months

Products of occupational therapy are sold and each patient is "paid" in tobacco or similar items for his contribution to the work For men, in particular tasks are provided for even the very severely handicapped For example, one group was engaged in pulling threads from loosely woven scraps of cloth These threads when wadded together became the waste which engine operators use to wipe their oily machinery Other more capable men used strands of rope to fabricate chair and stool seats Women's tasks seem less varied and are largely restricted to handwork

In all, the annex is bright and clean The residents give the impression of being well cared for and contented In this perhaps it typifies the Netherlands approach to the mental health problems of the aged—thorough, imaginative, and therapeutically sound The Dutch are vigorously aware of ... Their ... many fronts, and, ... is still developing its major objectives are well within sight

IV DENMARK

A visitor to the psychiatric wards of Copenhagen's Bispebjerg Hospital is struck by the apparent crisp efficiency of its operation, the absence of locked doors, the sparkling cleanliness, and the relative preponderance of patients who have reached the mature years of life Crowding, however, is not evident, although Denmark shares this problem with other western European countries Only later, upon visiting the two wards for senile patients set up in adjacent temporary wooden buildings, does the nature of the problem and the steps taken to achieve partial solution become obvious.

Faced with an increasing number and proportion of long term patients, the hospital sought relief to pressing space problems by temporarily housing aged, mildly psychotic individuals in these one story buildings located just a few paces from the entrance to the main psychiatric wards Although used longer than anticipated, these wards are slated for early replacement by two new nursing homes for senile patients to be constructed within the city of Copenhagen

These temporary quarters have served their purposes well, not only by releasing space in the main wards for active treatment of acute patients, but also by giving the aged patients a more appropriate thera

tions So important are these homes to the functioning of the plan that the setting-up of more centers in Amsterdam is awaiting the completion of the nursing home building program

The primary objective of the consultation centers is not of course, the placing of frail, aged people into various kinds of institutions and homes, rather it is the marshaling of all community resources to prolong the independence of the older person

3 *Clubs* —*Organized clubs for the aged* have an important place in the over all mental health program While the activities and functions of the clubs are valuable in and of themselves, the Department of Mental Hygiene finds them extremely useful as a device for early case finding As Dr Querido says, membership "puts a handle" on the older person so that the various services available to the individual can be quickly brought to bear in the event of trouble Participation in club activities puts the individual in contact with others who naturally become interested in his welfare Absence from club meetings may be noticed, inquiries can be made, and if necessary, help can be sent Changes in health or behavior may become apparent early and corrective measures suggested and encouraged

In Amsterdam there are about 120–30 clubs for the aged, with a combined membership numbering in the thousands In general, programs are simple and uncomplicated Meetings are held several times a week, usually in quarters provided by another organization, often a church Of course, club membership is considerably larger than actual attendance The exact number of clubs and their membership is not known, but for all of the Netherlands estimates range between 1000 clubs with a total membership of 50,000 to 1500 clubs with 100,000 members Dr R J van Zonneveld, of the Gezondheidsorganisatie T N O , believes that the actual figures lie somewhere between these two estimates

D Personnel

There are in the Netherlands about 350 psychiatrists Many of these are in private practice, and a great number combine private practice with work in the mental hospitals and various governmental services Some 40 of the 55 psychiatrists practicing in Amsterdam contribute a portion of their time in order to give psychotherapy to ambulatory patients of the various treatment centers of the city They are compensated for these services by grants from the municipal Public Health Service to the treatment center A shortage of psychiatrists exists, and it is estimated that the number in private practice in Amsterdam could be doubled to meet existing needs

In spite of shortages in numbers, the services of psychiatrists are fairly evenly distributed throughout the country and equally available to all citizens In Amsterdam in 1955 there were 22 treatment centers at polyclinics located in the city to treat ambulatory patients under the health insurance system Each of these centers has a psychiatrist attached to its staff

The city's mental hygiene service usually has 12 psychiatrists attached to it, plus 4 or 5 psychiatrists in training Twenty five psychiatric social workers complete the professional staff in this service Some psychological services are provided through the university It is felt that the use of psychiatrists in the mental hygiene service is efficient and economical One psychiatrist working in this service is believed to be "more effective than the whole personnel of a fifty bed ward' (Querido, 1948)

A national shortage of nurses for psychiatric patients exists and is an important contributing factor to the 12–15 per cent overcrowding that is thought to exist in the nation's mental hospitals In early 1958 some pavilions in hospitals were standing idle because of the lack of nursing personnel Easing of this shortage would enable the present hospital capacity to be increased by 1000 patients In Amsterdam the present nurse to-patient ratio in psychi

mately 3,500 000 inhabitants This rate was considered by the commission as a clear indication of insufficient hospital space, particularly in view of higher ratios achieved by other countries with which comparisons were made

At the time of the report Denmark's provincial psychiatric hospital needs were served by seven hospitals varying in size from about 250 to just over 1000 bed capacity All but two of these, however, had average daily treatment loads during 1950–51 ranging between 829 and 1046 patients Thus the average provincial Danish hospital was, as shall be seen later, larger than the commission thought for best therapeutic results

Table 9 also shows that *nursing homes* and *supervised family placement* serve a minor, but still substantial, share of the total number of patients under treatment. The former since the patients they serve are primarily seniles and mild chronic schizophrenics are of particular interest to us. Not all hospitals have these homes associated with them and further extension of these units is contemplated

C Increased Demands for Hospital Space

The Danish commission has attempted to account for the increase in demand for mental hospital space in a way similar to that adopted by the French Ministry of Health in their investigations reported earlier in this chapter It is not surprising that many of the conclusions in the two studies are almost identical

In the commission s report three related groups of factors were studied These were *population factors, morbidity or incidence of mental disease,* and *hospital factors* Recommendations with reference to hospital development grew out of this analysis

POPULATION FACTORS

Three aspects of population have particularly important bearing upon psychiatric hospitalization trends The first, of course, is the size and growth trend of the total population, second, the age structure of the population, and, finally, the rural urban ratio and the nature of the trend toward urbanization Age structure and rural urban ratios are important because incidence of mental disease varies with both Tables 10 and 12, as well as Figure 2, not only show clear-cut age differences in incidence of hospitalization but also indicate age influence upon type of disorder encountered

We have already noted in Table 9 a hospitalization rate for mental illness in provincial Denmark of 2 17 patients per 1000 population For various reasons the commission felt that a ratio of 2 50 per 1000 must be accepted as the absolute minimum

Failure to increase the number of beds between 1940 and 1950, owing to the stringencies of the occupation and the aftermath of war, actually led to a decrease in capacity relative to population during this period In order to make up this lost ground, 800 new beds would have been required in 1950, and an additional 350 beds would have been necessary to reach the desired proportion of 2 50 per 1000 Taking into account that modernization will require the elimination of some of the existing capacity, it is estimated that 5200 new beds must be provided by 1970 in order to meet and maintain the above standard by that time

This assumption is based upon the further assumption that the demand for mental hospital beds will remain unchanged Increasing urbanization in Denmark, however, may lead to a mounting demand for space because city hospitalization rates tend to exceed those of rural areas. In Copenhagen in 1950, for example, there were 3 2 mental patients for every 1000 inhabitants of the city, and similar experience is to be expected in other urban areas of Denmark *In 1950* the urban and rural populations were about equal, but present trends seem to indicate that by 1970 approximately 60 per cent of the population will live in city areas This de-

peutic environment That they have not fully solved the space problem is indicated by the fact that early in 1958 a waiting list of about twenty-four aged persons existed for places in these two wards Some patients must wait for as long as 12–18 months for entry Admission priority is based upon the medical, psychological, and social needs of the case

The necessity for central convenient location of these segregated nursing homes for aged mental patients has been demonstrated by the Bispebjerg Hospital experience Dr Carl Clemmesen, chief of the hospital's Department of Psychiatry, found that during a 1-year period these patients had an average of nine visits from family members or friends every 10 days At the same time, similar aged patients in another of Copenhagen's institutions some 30 miles from the city itself received practically no visitors Obviously, the new nursing homes will be built within the city in accessible locations

A Mental Health Interest in Denmark

In Denmark all psychiatric hospitals, with only two exceptions, are under the administrative direction of the State Mental Health Service The exceptions are the hospital operated by the city of Copenhagen for its residents and one private institution A realization that development of the mental hospital system had come to a standstill during World War II and the years preceding it led in 1952 to the appointment of a commission by the Danish Ministry of Internal Affairs to study the situation and to make the necessary plans for improvement As a result of the work of this body a reorganization program involving the extension and modernization of the mental hospital system was started in 1953

The final report of the commission was published in 1956 (Denmark, Ministry of Internal Affairs 1956, Stromgren, 1958) It is interesting to note that the formation of the commission and the resultant developmental plans came about in large measure in response to popular demand sparked by considerable public discussion of the needs of the mental hospitals Realization that new approaches to therapy for mental patients would be compromised, if not denied, by acute lack of space in the psychiatric hospitals led to an emphasis upon elimination of hospital overcrowding as the major focus of the task

B The Hospital System and Its Needs

Table 9 gives the average daily number of patients in psychiatric hospitals administered by the State Mental Health Service for the period April 1 1950 to April 1 1951 This figure does not include patients in St Hans Hospital which is operated by the city of Copenhagen or in the private mental hospital alluded to earlier The former hospital located outside the city proper cares for some 2200 patients while an additional 350 beds are maintained in wards of Copenhagen hospitals The population of the city is approximately 1 200, 000 (LeMaire, 1956)

The rate of 2 17 patients for 1000 population is based upon a provincial population (excluding Copenhagen) of approxi

TABLE 9*

AVERAGE DAILY NUMBER OF PATIENTS UNDER TREATMENT IN INSTITUTIONS ADMINISTERED BY THE DANISH STATE MENTAL HEALTH SERVICE, APRIL 1 1950 TO APRIL 1 1951†

	No of Patients	Rate per 1000 in the Districts Considered‡
Mental hospitals	5461	1 55
Nursing homes	1242	0 35
Family care	917	0 26
Total	7620	2 17

* Source Ministry of Internal Affairs *Betænkning afgivet af kommissionen af 29 marts 1952 vedrørende Statens sindssygevæsen* (Copenhagen Statens Trykningskontor 1956)

† Does not include Copenhagen hospitals

‡ Based upon a population of 3 513 170 excluding Copenhagen (November 7 1950)

trated by the growing proportion of long stay patients in all state hospitals In 1937, patients who had been in the hospital 10 years or more were 35 per cent of the total but by 1952 this group had increased to 51 per cent

Inspection of Figure 2 shows not only an increasing rate of hospitalization of aged people since 1937 but also a decreasing rate for younger age groups Since it is unlikely that there is any decrease in morbidity in the latter group the explanation lies at least in part in more effective treatment of mental illness in younger people The commission expresses the suspicion however, that hospital overcrowding may be responsible in some measure by restricting the number of young admissions

MORBIDITY

Predictions of future trends in mental illness depends upon a number of factors not the least of which is the influence of therapy upon the course of the various illnesses subsumed under this broad and general term Intelligent predictions must be carried out therefore with substantial knowledge of the incidence of the common types of mental diseases and of the way they are likely to be affected by both cur

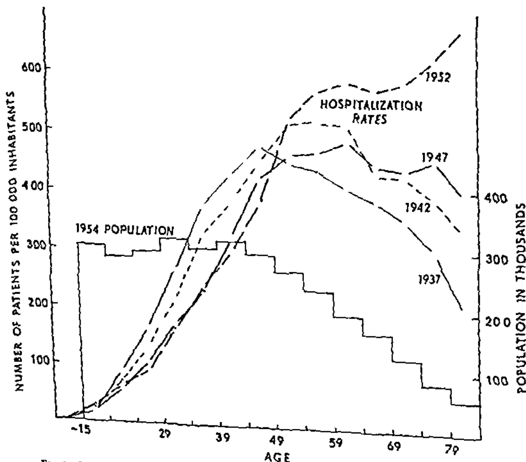


FIG 2.—Hospitalization rates for patients under treatment in state mental hospitals and the estimated (1954) population of Denmark, by age (After Erick Stromgren "Mental Health Service Planning in Denmark," *Danish Medical Bulletin* 5 [1958] 14 Table 3 and World Health Organization *Annual Epidemiological and Vital Statistics 1954* [Geneva The Organization 1957] Table 2)

velopment, therefore, should accentuate the demand for hospitalization

AGING OF THE POPULATION

Another population factor likely to influence the estimates of need for mental hospital space by 1970 is increasing age of the total population which Denmark shares with other western European and North American countries Table 10 and Figure 2 show clearly not only the influence of age upon rate of hospitalization for mental disorder but also the rapid rise since 1937 in these rates for older people As the proportion of aged in the population increases, it is inevitable that the trend will be reflected in the mental hospital

That this has occurred is indicated by the fact th - ^^
per cent of
tients were
by 1952 this proportion had increased to no less than 35 per cent At first conjecture it would seem entirely reasonable to account for this rapid shift in age structure of the hospital population by the disproportionate admission of aged people The commission believes that this may indeed have occurred to some extent in the city of Copenhagen but it finds little to support the hypothesis in the experience of the state psychiatric hospitals as indicated by the data presented in Table 11 While these figures are from one hospital only, the commission believes that they are typical

TABLE 10*
HOSPITALIZATION RATES BY AGE FOR PATIENTS UNDER TREATMENT IN STATE MENTAL HOSPITALS OF DENMARK

Age	No of Patients per 1000 Inhabitants in				Population Estimated July 1 1954†
	1937	1942	1947	1952	
Under 15	0 01			0 01	
15–19	0 19	0 22	0 21	0 30	306 400
20–24	0 88	0 72	0 60	0 66	287 000
25 29	1 65	1 36	1 07	0 91	296 700
30–34	2 64	2 12	1 71	1 61	318 800
35–39	3 72	3 26	2 33	2 35	301 700
40–44	4 25	3 78	3 21	2 98	314 500
45–49	4 71	4 48	4 16	3 76	294 900
50–54	4 45	5 07	4 58	5 15	264 200
55 59	4 36	5 11	4 62	5 62	234 800
60–64	4 05	5 09	4 80	5 78	193 400
65–69	3 82	4 27	4 41	5 66	161 700
70–74	3 52	4 25	4 32	5 75	121 600
75 79	3 02	3 89	4 50	6 13	80 500
80 and over	2 10	3 35	3 95	6 69	58 500
Total	2 05	2 13	1 96	2 19	

* Source E Strömgren Mental Health Service Planning in Denmark *Danish Medical Bulletin* 5 (1958) 1 17 as adapted from Ministry of Internal Affairs *Betænkning afgivet af kommissionen af 20 marts 1952 vedrørende Statens sindssygevæsen* (Copenhagen Statens Trykningskontor 1956) Table 3 p 14

† *Annual Epidemiological and Vital Statistics 1954* (Geneva World Health Organization 1957) Table 2

What is believed, therefore, to account for the increased aging of the hospital population *is not selective admission* but rather a cut in the death rate, particularly among chronic aged patients Supporting this is the fact that the aged patients at Aarhus are not in the main suffering from the senile psychoses but rather are primarily schizophrenics who have grown old in the hospital This point is further illus

ing homes or to family care It is assumed that a great proportion of the former group of patients at least would fall within this diagnostic category The investigators assume however, that the proportion of seniles is likely to increase in the future because no effective therapy has as yet been found for this group and because the present successful treatment of intercurrent physical diseases serves to increase the length of hospitalization

It is felt that modern therapeutic procedures will in all probability effectively reduce the number of cases in only two categories general paralysis and reactive psychoses Since these two combined comprise only about 8–9 per cent of the hospital patients not much relief from overcrowding can be expected from this quarter Danish planners conclude that it is 'unreasonable to expect psychiatric therapy however much it may advance in the next ten years to decrease the demand for psychiatric hospital beds

HOSPITAL FACTORS

Mental hospitals like department stores offer a service to the public And like department stores their acceptance by the public depends upon a number of factors among which two are prominent location and quality of service offered Danish planners attempted to assess the possible influences of both of these factors upon future use of hospital services Experience had already abundantly shown that admission frequency varies inversely with distance from the hospital that is patients more frequently tend to come from regions immediately surrounding the hospital than from more distant areas Since it was felt that the building of relatively small units more or less evenly distributed in population centers throughout the country was the most desirable way to proceed with expansion of the hospital system consideration had to be given to possible effects this distribution might have on utilization

Similarly it was known that crowded conditions with insufficient staff to give prompt treatment and attention affects adversely the hospital s reputation and inevitably its utilization Since it is impossible to assess accurately the influence of these two factors, it was decided to base the quantitative estimate of hospital needs upon the expected and projected increases in the total Danish population As a hedge against possible error, however, a flexible building program was adopted, which could be achieved best by operating small units. This plan was favored both for the additional therapeutic values offered and because of its adaptability

Recalling that the Danish Mental Health Service operates three different types of care (i e mental hospital, *nursing home* and family care), attention was given to possible future trends in the distribution of patients among these three From experience *in regions in* which all three types of care are offered no major change in the proportion of hospital population vis à vis the combined total of the other two forms of care was anticipated

It was anticipated nevertheless, that in the future fewer homes would be available for family care and additionally, that the newer forms of therapy would demand that some patients formerly *placed in nursing* homes and with families as mild chronic cases could now be treated successfully in the hospital proper Since these trends could be a matter only of conjecture at best the ratio of 70 *per cent hospital* patients and 30 per cent *for family* and nursing home placement was retained However, it was thought most desirable *to place* the nursing homes close by the controlling hospital so that necessary therapeutic supervision could be easily maintained

D Plans for Development

The commission s study led directly to the formulation of broad plans for improvement *of the* State Mental Health Service Six of the seven existing mental hospitals were to be thoroughly modernized

TABLE 11*

ADMISSION OF PATIENTS AGED 60 AND OVER TO A DANISH STATE MENTAL HOSPITAL (AARHUS) FOR THE PERIOD 1910–50

Year	All Admissions	Admissions over Age 60	
		No	Per Cent of All Admissions
1910	104	12	11 5
1915	142	13	9 2
1921	233	30	12 9
1925	221	21	9 5
1930	266	26	9 8
1935	252	28	11 1
1940	359	53	14 8
1945	515	69	13 4
1950	619	52	8 4

* Source Ministry of Internal Affairs, *Betænkning afgivet af kommissionen af 29 marts 1952 vedrørende Statens sindssygevæsen* (Copenhagen Statens Trykningskontor, 1956), Table 4B, p 148

rent and developing therapeutic methods For this reason the Danish commission conducted a study of all cases under treatment in one of the country's major mental hospitals. Partial results of this study are presented in Table 12.

The major objective of this investigation was to determine what, if any, factors were operating in the case of each patient which might influence his early discharge. These included kind of treatment being received, possibilities for the use of as yet untried therapies, physical condition of the patient as it might affect his response to treatment, age, sex, diagnosis, and other factors.

At first glance perhaps the most surprising finding is the low incidence of senile psychosis in the hospital population (Table 12). This is the less remarkable when it is recognized that the population under study does not include patients assigned to nurs-

TABLE 12*

DISTRIBUTION OF PATIENTS UNDER TREATMENT IN A DANISH STATE MENTAL HOSPITAL (AARHUS) ON JANUARY 28, 1953, ACCORDING TO AGE AND DIAGNOSIS

Age	General Paralysis	Senile	Epilepsy	Other Organic	Schizophrenia	Manic Depressive	Reactive Psychosis	Neurosis	Psychopathy	Alcoholism	Drug Addiction	Mental Deficiency	Total
10–14							1	1					2
15–19					4	5	2	2				2	15
20–24					14	4	3	2	2			1	26
25–29					19	2	4	1	4			2	35†
30–34			1	2	30	5	4	1	7	2		3	55
35–39			2		49	9	7	2	6	3	3	2	83
40–44			4	5	47	21	10	1	4	2	1	4	99
45–49	2		2	1	65	13	7	3	5	2		4	105‡
50–54	2	1	1	2	67	15	6	2	5	1	1	1	104
55–59	8	5		3	49	20	2	1	2	1	2	1	94
60–64	8	4	1	1	49	21	2					1	87
65–69	2	6		2	22	20						1	53
70–74		14			11	14			1			2	42
75–79		11			3	2							16
80–84		10			3								13
85–89		7											7
90–94					1								1
Total	22	58	11	16	433	151	48	16	36	11	7	24	837
Per cent	2 6	6 9	1 3	1 9	51 7	18 0	5 7	1 9	4 3	1 3	0 8	2 9	100

[illegible] *kommissionen af 29 marts 1952 vedrørende Statens sindssygevæsen* [illegible]

fully realized the importance of providing all
... stance and

nection be noted that when the new psychiatric
... parts

Affairs 1956]

SEPARATE UNITS FOR CHRONIC TREATMENT

Since psychiatric hospitals are designed to give active treatment of various sorts to patients suffering a number of different disorders, it is unwise and uneconomical to occupy large portions of these hospitals with chronic patients for whom only limited treatment is required. Therefore the commission proposed to build new ward homes to supplement the nursing homes already in existence to care for these patients, most of whom are seniles. These homes are to be b...

Each home is to be limited to 250 patients who will live in wards of no more than 24 patients each. Some single rooms will be provided, and no room will be occupied by more than 4 patients. Buildings will all be constructed on one floor, with each ward having direct access to gardens which are considered as part of the treatment facilities of the home. The buildings will be connected for ease of communication and so that common supervision can be provided ... ter

city architect of Copenhagen is intended for mentally confused senile patients too ill for placement in a home for the aged yet who should not be placed in a regular mental hospital ... is its ... tral ... the patients

PLACEMENT OF MENTAL HOSPITALS AND NURSING HOMES

Figure 3 gives the location of Denmark's present and proposed mental hospitals and *nursing homes*. Denmark's population of about 4,500,000 puts it roughly in the same class as Massachusetts, Indiana, Missouri and North Carolina. Since it is composed of a peninsula and a number of islands, it is difficult to estimate the effective distances between the various parts of the country; however, some idea of size may be obtained by noting that the straight line distance between Copenhagen and Aarhus is about 90 miles and that a flight of about 200 miles in any direction would ...

E. Mental Hospital Staff

MEDICAL STAFF

The ordinary Danish mental hospital has about eight physicians on its staff, although the full complement is often difficult to maintain. A medical superintendent heads the unit, assisted by two senior assistants. The remainder of the medical staff consists of 'junior psychiatrists' who stay with the unit for periods of 1–5 years.

Work loads in recent years have placed heavy burdens on the medical staff which could not be effectively lessened by the addition of more junior staff. Since the medical superintendent bore the brunt of much of the work increase, it was decided to increase the number of medical superintendents and thereby decrease the size of units.

NURSING

In the past, Danish nurses served 6 months in a psychiatric hospital in addition to their 3 years of basic training in order to qualify as psychiatric nurses. At present a 4 month ... to them ... their 3 ...

Fully trained psychiatric nurses form,

and the seventh to be converted into a nursing home Twelve new hospitals and seven new nursing homes were planned In all, over $50 million are to be spent in carrying out the program—no mean expenditure for a country of only 4 500 000 population

In arriving at its recommendations the commission carefully considered three aspects of the mental hospital in relation to the perceived needs of the nation These were the function of the hospital in relation to the total medical armamentarium its size and its placement in the community Departing from the traditional pattern of large and expanding hospitals it was decided that the ideal size for new mental hospital units would be from 300 to 350 beds It was believed that units of this size were large enough to offer well rounded treatment and would permit the establishment of the several necessary types of wards within its structure

The small size of the units also made possible the placing of these projected institutions close by existing and anticipated general medical hospitals The feeling was strong that general medical and psychiatric hospitals should be near each other so that clinical knowledge and experience as well as the therapeutic facilities of the two types of institutions could be brought to bear on the patient s needs This opinion was so generally held that in 1948 the plans to build one mental hospital were scrapped because the site selected was 2 miles from the nearest general hospital It was said not only that the distance was too great between the site and the general hospital but also that the latter was too small to fulfil the anticipated demands for services

PSYCHIATRIC HOSPITALS OR PSYCHIATRIC CLINICS AS A PART OF GENERAL HOSPITALS?

The Expert Committee of the World Health Organization referred to earlier discussed the feasibility of limiting future mental hospital development to clinics or sections of general medical hospitals While seeing many advantages to this arrangement they did not feel that these units supplanted the needs for separate psychiatric hospitals In a similar way the Danish planners faced this problem and arrived at a not too dissimilar solution

The attitude toward general hospital psychiatric wards was very favorable and experience with this arrangement proved entirely satisfactory In one provincial general hospital where this arrangement was tried it was discovered that the number of patients treated annually increased in both the psychiatric wards and the medical and surgical wards although the number of beds remained unchanged after the integration of the formerly separate units This increase in bed utilization came about because patients hospitalized for somatic reasons received prompt psychiatric care when it was required and similarly mental patients when necessary were given early and expert treatment for physical disorders This combined therapy led to early discharge of many patients who otherwise might have occupied beds for needlessly extended periods of time

Nevertheless abandonment of psychiatric hospitals or turning them into isolated chronic institutions was rejected for several reasons Among these is the fact that psychiatric clinic patients and hospital patients are not identical and that considerable need exists for the kind of care that is offered by the mental hospital It was further feared that clinics might tend to attract too great a proportion of professional staff already in short supply there by tending to downgrade psychiatric hospitals to secondary institutions suitable only for chronic and intractable patients

Taking the entire critical situation into account it was decided that the first plan must adopt as its primary aim the building of new psychiatric hospitals In addition the commission stated that it

In the main, social work has been carried out by nurses who have had some special training for this work. More and more, however, trained social workers are being hired to carry out this function.

An increasing demand for the services of psychologists has also been felt, this profession, however, is in such short supply that most psychologists in the mental hospitals are fully occupied with diagnostic testing. In some child psychiatry units, nevertheless, they take part in therapy, but at present this is rarely the case with adults.

F. The Aged Patient

Danish mental hospitals do not feel that the admission of senile patients now provides them with any special problems. They believe however that pressure can develop before many years. It has already been noticed that an appreciable number of residents of homes for the aged and ordinary nursing homes exhibit sufficiently marked signs of confusion and mental aberration to make reasonable their placement in a psychiatric hospital. Should this be done, however, fear[illegible]

[illegible] disorders of this type can be adequately handled in these non psychiatric institutional settings. When more acute phases develop characterized by marked confusion agitation and delirium then psychiatric hospitals must be prepared to receive these patients. On this point the commission says:

> One might consider the establishment of special wards in the psychiatric hospitals as well [illegible]

It is obvious from this discussion that Denmark is not following a policy of rigidly separating the mentally ill aged from the more or less normal population in its homes for the aged. With this point in mind, it may be well to examine briefly that portion of Denmark's population which resides in her homes for the aged.

HOMES FOR THE AGED

In 1955, Danish municipalities and community councils were operating a total of 563 homes for the aged. As shown in Table 13, over 14,000 individuals lived in these institutions, and all but 741 of them were state pensioners. Not included in Table 13 are the substantial number of old people (some 4000) who live in homes or institutions supported by private foundations or organizations (Denmark, Ministry of Labor and Social Affairs, 1957*a*).

Although Denmark had in 1955 accommodation in homes for the aged for about one in twelve of its 200,000 old age pensioners and offered many services designed to enable them to live independently, it was, nevertheless, felt that some expansion would be necessary in the number of homes for the ill aged. It is not suggested that this program be integrated with the system of nursing homes proposed by the Mental Health Service.

G. Mental Deficiency and Age

Mental deficiency is generally considered to be a problem of childhood, and indeed it is common parlance to refer to the mentally deficient of all ages as "children." Inspection of Table 14, which gives the age distribution of the mentally retarded under the care of Denmark's Østifternes Åndssvageanstalt, shows clearly, however, that these individuals are represented in every age group including those above 70. Even though the latter are relatively few in number, they do present a special gerontologic problem.

STATE RESPONSIBILITY FOR CARE

For many years the community has assumed the responsibility for the care of this

however, only a portion of the nursing staff, which is augmented by male and female nurses who have received a year of training in a psychiatric hospital but no other formal nursing training In male wards in particular the products of the 1 year courses outnumber the fully trained nurses This situation is not likely to change in the near future, but improvement in *teaching of this group can be expected*

OTHER PROFESSIONAL STAFF

Additional specialized personnel is beginning more and more to assume responsibility in the total therapeutic process of the hospital Among these are occupational therapists, physiotherapists, social workers, and psychologists While occupational therapy is still largely carried on by nurses, specially trained occupational therapists are being added to the staff Much occupational therapy is aimed at keeping patients busy in the most advantageous way during their period of hospitalization, however, during recent years this work has been increasingly directed into channels likely to be useful to the patient upon his discharge Extension of this idea has led to patients being given vocational training opportunities outside the hospital in preparation for release

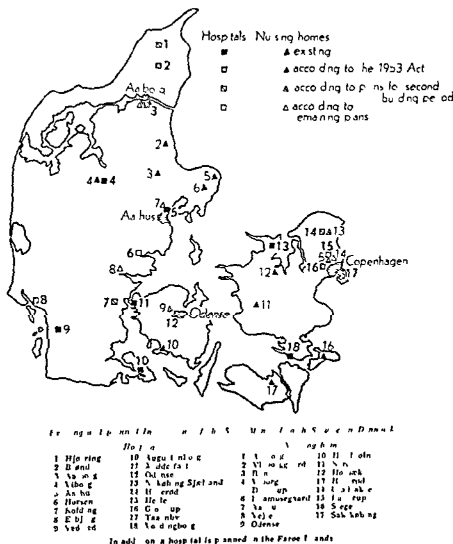


FIG 3—Existing and planned institutions of the State Mental Hospital Service in Denmark (From Erick Stromgren 'Mental Health Service Planning in Denmark *Danish Medical Bulletin*, 5 [1958] 22)

excess admission of older persons, since only 5 per cent of the 6869 patients shown in Table 14 were admitted after the age of 40, and only 109 of the entire group reached 50 years of age before admission Since a total of 836 individuals were 50 years of age or over at the time of the survey, it is apparent that the majority of older patients were admitted to supervisory care earlier in life The overcrowding to be expected from the older age groups among the mentally retarded quite apparently results from the aging of the population under supervision rather than from new admissions

TABLE 15*

MENTAL HOSPITALS AND PSYCHIATRIC CLINICS IN THE NORTHERN COUNTRIES 1954

	Denmark	Finland	Iceland	Norway	Sweden
1 No of beds	10 309	9 977†	240‡	6 614	29 425§
2 Beds per 1000 population	2 34	2 35	1 56	1 95	4 07
3 Admissions during year	19 688	10 731	141	2 948	19 091
4 No of patients treated during year	29 452	20 482	426	11 579	
5 No of days treatment (in 1000 s)	3 518	3 610	104	2 998	11 814
6 Percentage occupancy	97	99	119	124	‖
7 Population (in 1000 s)¶	4 405	4 245	154	3 392	7 230

* Source Con...

V SWEDEN

Of the five northern countries—Sweden Denmark Finland Iceland and Norway—Sweden is the largest in population and area Her seven and a quarter million people are approximately one third the combined population of these five countries within her boundaries lies 36 per cent of the land area (World Health Organization 1957a)

Along with the other nations in this group Sweden shares a progressive social outlook In percentage of national income devoted to social expenditures which cover outlays for various health services including mental health she ranks a close second behind Denmark Thus in 1955, 12 1 per cent of the Danish national income went for social expenditures and services, Sweden followed with 11 6 per cent, Finland, with 10 5 per cent, Norway, with 9 1 per cent, and Iceland with 8 9 per cent (Conference of the Ministers of Social Affairs of the Northern Countries 1957)

Table 15 shows how these countries compared in 1954 in terms of the number of beds available for the treatment of the mentally ill in psychiatric hospitals and clinics Here we see that Sweden has the highest number of beds per 1000 population of all the northern countries If we use "percentage occupancy" as the basis for judgment both Denmark and Finland appear to have just enough beds to cover their immediate needs On the same grounds Iceland and Norway evidence considerable overcrowding reporting 119 and 124 per cent occupancy While Sweden reports no comparable statistic, overcrowding is felt to exist even though in terms of beds per 1000 population it is considerably over the World Health Organization norm of 3 beds per 1000 and commands an even more impressive lead over most other western European countries (Conference of the Ministers of Social Affairs of the Northern Countries 1957) We do know from an

particular group of mentally handicapped. As is apparent in Table 14, about 50 per cent of these individuals are maintained in institutions, the remainder being placed under supervised extramural care.

In the last column of Table 14 the percentage of each age group being cared for in an institution is given. These percentages are highest between the ages of 3 and 14 and over the age of 50. This suggests that older mentally deficient persons, particularly those above the age of 50, are less likely to be suitable candidates for supervised extramural care than are younger adults.

Responsibility for the mentally deficient in Denmark rests with two separate administrations covering more or less separate geographic areas. Each has approximately one-half of the total number of the mentally retarded under its care. Since the statistics in Table 14 are for only one of these administrative units, it is necessary to double the figures presented in this table in order to estimate the total number of mentally deficient persons under supervision in the country.

The accumulation of patients in the older age groups apparently does not stem from

TABLE 13*

NUMBER OF RESIDENTS IN DANISH HOMES FOR THE AGED BY AGE AND TYPE OF CONTROL†

Age	Owned by Local Governments			Privately Owned		Total
	I Metropolitan Copenhagen	II Provincial Towns	III Rural Communities	II Provincial Towns	III Rural Communities	
60–64	52	115	130	1	25	323
65–69	198	435	508	4	53	1,198
70–74	445	1037	1066	10	77	2,635
75–79	593	1659	1666	28	102	4,048
80 and over	1026	2917	2393	45	168	6,549
Total	2314	6163	5763	88	425	14,753

* Source Ministry of Labor and Social Affairs *Alderlomshjemmene og deres beboere* (Copenhagen, 1957) Table 10, p 12

† Does not include some 4000 residents in homes supported by private foundations and trust funds

TABLE 14*

MENTALLY DEFICIENT INDIVIDUALS UNDER SUPERVISION OF ØSTIFTERNES ÅNDSSVAGEANSTALT, DECEMBER 31, 1953

Age (In Years)	Male	Female	Total	No. In stitutions	Per Cent of Age Group
0– 2	23	28	51	13	25 5
3– 6	186	131	317	191	60 3
7–14	592	410	1002	645	64 4
15–19	496	354	850	471	55 4
20–29	874	721	1595	618	38 7
30–49	1141	1077	2218	1016	45 8
50–69	383	363	746	452	60 6
70 and over	44	46	90	63	70 0
Total	3739	3130	6869	3469	50 5

* Source Henning Friis *Personer under Østifternes Åndssvageanstalts forsorg* (Copenhagen, 1955), Table 4, p 15

aged 853 beds This downward trend is somewhat accentuated by lessened use of these wards, for during the same 3 year period percentage occupancy dropped from 97 to 91 (Sweden, Central Bureau of Statistics, 1956) This trend is to be expected in view of Sweden's policy of reserving its old age homes exclusively for relatively well aged individuals who need minimum assistance in day to day living In following this policy, all chronic cases, including mentally ill, are made the responsibility of the Ministry of Health and its various agencies Arrangements for their treatment must be

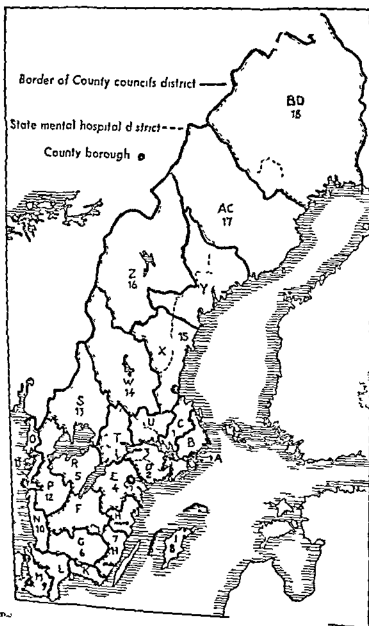


Fig. 4.—D…

…edical Board, *Allman*

other source however, that in 1955 the Swedish state mental hospitals reported 117 per cent occupancy and the mental hospitals of the three largest cities reported 102 per cent occupancy for the year The high figure for the state mental hospitals was felt to be somewhat exaggerated since certain reserve beds were not taken into consideration (Sweden, Royal Medical Board, 1957)

A Mental Hospitals

Public health and sick-care activities in Sweden are either operated or controlled by public authorities This work is under the general direction of a cabinet minister while administrative responsibility is vested in the Royal Medical Board which has direct control of the state mental hospitals along with numerous other administrative supervisory and promotional functions

The main part of the administration of health and sick care has been delegated to local authorities The twenty five county councils and six county boroughs see to it that the sick receive necessary hospital care The county council districts correspond to the twenty four counties one of which is divided into two districts These districts are indicated in Figure 4 by capital letters and by the six small black circles for the county boroughs The care of the mentally diseased however has been taken over almost completely by the state only the three largest cities (Stockholm Gothenburg and Malmo) have their own independent organization The various state mental hospital districts are designated in Figure 4 by the numbers *1* through *18* (Sweden Royal Medical Board 1957)

In 1954 the mental hospitals of the state and of the three largest cities had a capacity of 25 597 beds municipal and private hospitals 910 beds and homes for the mentally diseased 4829 beds (Sweden Central Bureau of Statistics 1956) Since 1951 the municipal and private hospitals have diminished in capacity although the total number of beds in the three combined resources increased during the period 1951-54 by 904 places (see Table 16) Most of this small gain can be attributed to the rise in capacity of the homes for mentally diseased

In Table 16 a comparison of the number of beds available for the treatment of somatic and mental illnesses is given for the years 1951–54 It is evident from these data that about one third of Sweden s hospital beds are devoted to the treatment of mental disease and that during these years the slight relative increase in total capacity did nothing to disturb this ratio materially That this trend has been going for at least a quarter of a century is shown in Figure 5 in which the number of beds for somatic illnesses is compared graphically with the number of beds for mental disease and mental deficiency

OTHER PSYCHIATRIC BEDS

Table 16 does not include the 747 psychiatric beds in general hospitals and similar establishments which were in use in 1954 (Sweden Central Bureau of Statistics 1956) Nor does it include the 1104 beds in Sweden s twenty one special institutions for the treatment of alcoholics In 1954 these *Alkoholistanstalterna* as they are called admitted 1432 patients of whom 384 or 27 per cent were above the age of 50 only 2 7 per cent however were 65 or more years old From the age distribution of admissions for the years 1947–54 it is evident that the vast majority of admissions into these institutions come from the age group 30–64 with the heaviest representation in the years 30–49 Alcoholism is not an evident problem of the aged in Sweden (Sweden Central Bureau of Statistics 1956)

HOMES FOR THE AGED

In addition to the above in 1954 there were 752 beds in approved wards for the insane in Sweden s 1357 homes for the aged These are apparently diminishing in number for in 1952 and 1953 they were

aged 853 beds This downward trend is somewhat accentuated by lessened use of these wards for during the same 3 year period percentage occupancy dropped from 97 to 91 (Sweden Central Bureau of Statistics 1956) This trend is to be expected in view of Sweden s policy of reserving its old age homes exclusively for relatively well aged individuals who need minimum assistance in day to-day living In following this policy, all chronic cases, including mentally ill are made the responsibility of the Ministry of Health and its various agencies Arrangements for their treatment must be

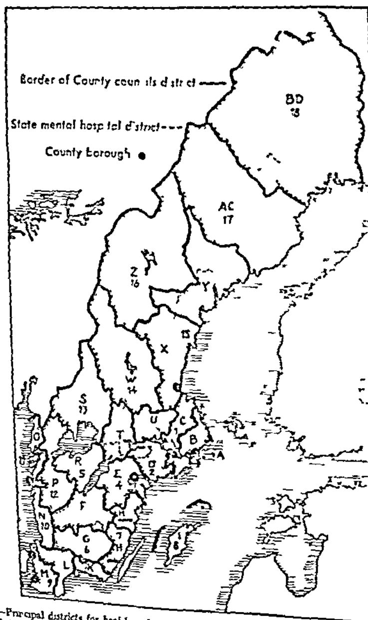


Fig 4—Principal districts for health and sick care in Sweden (After Royal Medical Board, *Allm a Hälso-Och Sjukvård 1955* [Stockholm Kungl Medicinalstyrelsen, 1957] p 30)

other source, however, that in 1955 the Swedish state mental hospitals reported 117 per cent occupancy, and the mental hospitals of the three largest cities reported 102 per cent occupancy for the year The high figure for the state mental hospitals was felt to be somewhat exaggerated, since certain reserve beds were not taken into consideration (Sweden, Royal Medical Board, 1957)

A Mental Hospitals

Public health and sick-care activities in Sweden are either operated or controlled by public authorities This work is under the general direction of a cabinet minister, while administrative responsibility is vested in the Royal Medical Board, which has direct control of the state mental hospitals, along with numerous other administrative supervisory, and promotional functions

The main part of the administration of health and sick care has been delegated to local authorities The twenty five county councils and six county boroughs see to it that the sick receive necessary hospital care The county council districts correspond to the twenty four counties one of which is divided into two districts These districts are indicated in Figure 4 by capital letters and by the six small black circles for the county boroughs The care of the mentally diseased, however, has been taken over almost completely by the state only the three largest cities (Stockholm Gothenburg, and Malmo) have their own independent organization The various state mental hospital districts are designated in Figure 4 by the numbers *1* through *18* (Sweden, Royal Medical Board, 1957)

In 1954 the mental hospitals of the state and of the three largest cities had a capacity of 25,597 beds, municipal and private hospitals 910 beds, and homes for the mentally diseased 4829 beds (Sweden, Central Bureau of Statistics, 1956) Since 1951 the municipal and private hospitals have diminished in capacity, although the total number of beds in the three combined resources increased during the period 1951–54 by 904 places (see Table 16) Most of this small gain can be attributed to the rise in capacity of the homes for mentally diseased

In Table 16 a comparison of the number of beds available for the treatment of somatic and mental illnesses is given for the years 1951–54 It is evident from these data that about *one third of Sweden's hospital* beds are devoted to the treatment of mental disease and that during these years the slight relative increase in total capacity did nothing to disturb this ratio materially That this trend has been going for at least a quarter of a century is shown in Figure 5, in which the number of beds for somatic illnesses is compared graphically with the number of beds for mental disease and mental deficiency

OTHER PSYCHIATRIC BEDS

Table 16 does not include the 747 psychiatric beds in general hospitals and similar establishments which were in use in 1954 (Sweden, Central Bureau of Statistics, 1956) Nor does it include the 1104 beds in Sweden's twenty one special institutions for the treatment of alcoholics In 1954 these *Alkoholistanstalterna*, as they are called admitted 1432 patients of whom 384, or 27 per cent were above the age of 50 only 2 7 per cent however, were 65 or more years old From the age distribution of admissions for the years 1947–54 it is evident that the vast majority of admissions into these institutions come from the age group 30–64 with the heaviest representation in the years 30–49 Alcoholism is not an evident problem of the aged in Sweden (Sweden, Central Bureau of Statistics, 1956)

HOMES FOR THE AGED

In addition to the above in 1954 there were 752 beds in "approved wards for the insane" in Sweden's 1357 homes for the aged These are apparently diminishing in number, for in 1952 and 1953 they aver

made outside the community homes for the aged

While complete separation is difficult to achieve this policy has allowed the Social Ministry to develop plans and assist in the construction of community homes for the aged which have no suggestion of hospital atmosphere Most however, do contain special facilities for the treatment of short term illness and a few have rather large sections devoted to the care of the chronically sick but these are not typical An example of the latter is Stockholm s splendid new Stadshagsgården which houses 206 aged persons in a most modern and handsome building Over half of the capacity of this home is devoted to individuals in need of very close medical and nursing attention

COSTS

Care of the mentally ill and mentally deficient accounts for a *major* share of Sweden s expenditures for public health and care of the sick Of a total of 1119 million kronor ($212 61 million) spent in 1954 on the various health services of the state and local governments almost 20 per cent went for the care and treatment of the mentally ill In 1954 this amounted to 217 million kronor ($41 23 million) of which all but 40 million were contributed by the state the remainder coming from county councils and from towns outside county councils Between 1951 and 1954 costs of these services rose sharply In the former year the outlay was 151 million kronor ($28 69 million) indicating an increase of 44 per cent in the space of 4 years During the same period total spending for health services which in 1951 was 815 million kronor ($154 85 million) rose by 37 per cent an increase which though substantial was clearly surpassed by the steeper rise in mental health costs It should be noted that all cost figures given here include both operation and construction expenditures (Sweden Central Bureau of Statistics 1956)

B Census Enumeration of Mental Illness

In each of Sweden's decennial censuses during the period 1860-1930 information concerning the number of blind deaf mutes mentally diseased and mentally deficient persons was gathered In these enumerations statistical records of mental hospitals and institutions for the mentally deficient as well as reports of municipal and provincial medical officers were consulted An additional and most important source of data was the local population records which for more than 200 years the parish vicars have been required by law to keep In these records are entered on a household basis each parishioner s name occupation birth record or date of entering the parish marital status with appropriate dates and date of death or of leaving the parish

In addition special records are kept of the blind deaf mutes the insane and mentally deficient These records of the mentally ill are based upon the vicar's personal knowledge of the individual plus what other supplementary knowledge he can get from mental hospitals or other institutions to which the parishioner may be sent from physician s reports, and from the records of other parish vicars This is no frivolous record and a great deal of effort in the past has been expended to insure accuracy Reporting to the vicar of cases of mental illness or deficiency is legally binding upon physicians certain other officials or administrators, and the heads of families Similarly when a patient is considered as fully recovered the appropriate notation is entered upon his record One reason for the scrupulousness of this official record is that according to Swedish law, persons mentally diseased or deficient may not enter into marriage except with special medical sanction (Larsson and Sjogren 1954)

These parish records have provided valuable material for census enumeration and genetic research alike, although special care and knowledge are required in their use

TABLE 16*

HOSPITALS FOR SOMATIC AND MENTAL ILLNESS IN SWEDEN, 1951–54

(Capacity in Number of Beds)

	No OF BEDS				INCREASE
	1951	1952	1953	1954	
Hospitals for somatic illnesses	58 994	59 906	61 020	61,895	2901
Hospitals for mental illnesses	30 432	30 657	30 870	31 336	904
Total hospital beds	89 426	90 563	91 890	93 231	3805
Percentage of total devoted to mental illnesses	34	34	34	34	0

* Source Central Bureau of Statistics *Statistisk Årsbok för Sverige* Vol 43 (Stockholm 1956 Table 300 p 254

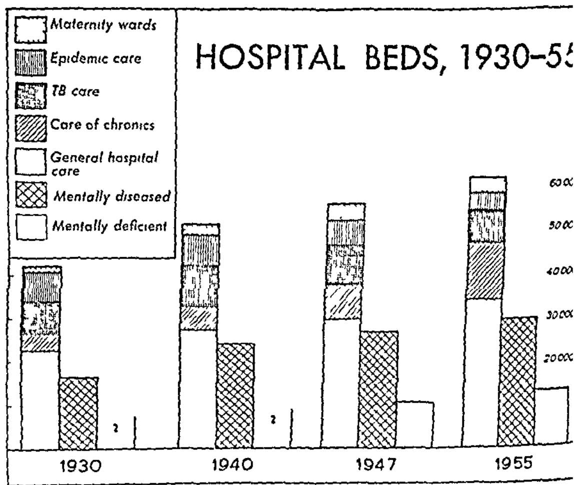


FIG 5—Number of hospital beds in Sweden by type of care 1930–55 (After Royal Medical Board Sweden *Allmän Hälso Och Sjukvård 1955* [Stockholm Kungl Medicinalstyrelsen 1957] p 30)

individuals previously affected and considered cured

The mental deficiency rates unlike those for mental diseases tend to diminish from the thirties onward Since mental deficiency is most likely to be incurred as a genetic or traumatic arresting of the developmental process the great majority of cases are to be found in childhood Since new cases are seldom discovered after adolescence or early adulthood the lessening in rate during middle age and beyond reflects the excess in mortality of this group Nevertheless the age groups beyond 60 are represented indicating that the aging mental defective cannot be ignored simply because he represents a lesser proportion of the total problem.

The relatively low prevalence ratio of mental retardation reported for the early ages is unquestionably artifactual and results from underreporting in infancy and childhood The somewhat higher prevalence for rural Sweden as compared with the entire nation may result from selective factors operating in the rural urban migrations of families with mentally defective members and perhaps to a small extent, from a slightly greater frequency of consanguineous marriages in isolated rural communities (Larsson and Sjogren, 1954) The latter factor appears to be associated to some extent with mental deficiency in offspring

D *Mental Hospitalization and Age*

The rapid rise in the number and proportion of aged in Sweden s mental hospitals can be illustrated by the experience of St Lars Mental Hospital at Lund (Hagnell 1954) As seen in Table 18 in the 70 years from 1883 to 1952 the percentage of patients over the age of 60 increased from 5 4 of a total patient population of 1451 to 20 3 of a population of 4876 This means that beginning in 1883 a twelvefold increase in numbers of this age group occurred in the course of seven decades Total hospital population increased during this time not much more than threefold The figures for the last decade are, if anything, an underestimation of this top-heavy age distribution for, in 1952, 29.3 per cent of the male patients and 26.8 per cent of the female patients were over 60 years of age

Figure 6 documents the not surprising fact that this increase in aged patients can not be accounted for by the general rise in the percentage representation of their age group in the general population. The distribution of first admissions over age 60 by diagnosis is given in Table 19 The 246 older patients shown here were among the 1028 patients of all ages admitted to St. Lars during 1951–52 Forty-seven per cent of these patients upon admission were diagnosed as suffering from a senile mental disorder senile psychosis, 34 per cent, psychosis with arteriosclerosis 12 per cent, and presenile psychosis, 1 per cent An additional 26 per cent were diagnosed as affective psychosis depressive, 22 per cent, and manic psychosis 4 per cent. Of the remainder, 15 per cent were classified as schizophrenia and 12 per cent as suffering from other diseases

TABLE 18*

Decade	Patients: Total No	Above 60 Years: No	Above 60 Years: Per Cent
1883 1892	1451	79	5 4
1893 1902	1172	92	7 8
1903 1912	727	70	9 6
1913 1922	990	110	11 1
1923 1932	2801	262	9 4
1933–1942	4124	373	13 8
1943 1952	4876	992	20 3

* Source O Hagnell, "Psychoses in the Aged an Increasing Psychiatric Problem *Nord Med* 51 (1954) 114

An nte
ps
at

They are, however, becoming less and less exact in view of a growing tendency not *to report cases of mild* psychoses even though admission to hospital for treatment has been effected

There are several reasons for emphasizing *this matter of parish* records It shows, for example, the very special way in which

*TABLE 17**

MENTAL DEFICIENCY AND MENTAL DISEASE IN SWEDEN ACCORDING TO DOMICILE SEX AND AGE DECEMBER 31 1930

Group	No of Persons Affected per 1000 of the Population in the Group			
	Rural Sweden		Whole of Sweden	
	Mental Deficiency	Mental Disease	Mental Deficiency	Mental Disease
Total population	3 5	4 5	2 9	4 5
Sex				
Men	3 8	4 5	3 2	4 5
Women	3 2	4 5	2 5	4 6
Age (in Years)				
0–10	1 0		1 0	
10–15	3 5		3 3	
15 20	4 5	0 5	4 0	0 5
20–30	4 7	3 2	3 7	2 9
30–40	4 3	6 8	3 2	6 4
40–50	4 2	8 7	3 1	8 5
50–60	3 9	9 9	2 9	9 6
60 and over	2 7	8 6	2 2	8 8

* Source T Larsson and T Sjögren, A Methodological, Psychiatric and Statistical Study of a Large Swedish Rural Population *Acta psychiat et neurolog Scandinavica* Suppl 89 1954)

mental illness has been regarded in Sweden and particularly the peculiar legal position of mental diseases which have traditionally set them apart from other illnesses Equally important for our purposes here it explains how Sweden was able to accomplish a reasonably accurate decennial census enumeration of mental disorders which was more than a recapitulation of hospital records

In the census of 1930 the last in which an enumeration of mental disorder was made in addition to consulting parish records, the head of every household was required to answer questions concerning the occurrence of certain *defects It was felt* that a *higher level of accuracy was* obtained in this census than in any of the previous ones in which data on mental health were gathered This census revealed 27,841 mentally diseased persons 17 571 mental defectives and 4349 epileptics (falling sickness) in a population of 6 142 191 persons (Larsson and Sjogren 1954)

RURAL URBAN PREVALENCE

In Table 17 some of the results of this census are presented Considering all age *groups it appears* that no difference in prevalence of mental disease exists between rural Sweden and the rates for the country as a whole This finding *is in* marked contrast to the usually reported higher urban incidence of hospitalization for mental illnesses It is a most important finding because *it lends substantive support to* the hypothesis that higher urban *hospitalization* rates may be associated with those conditions of city life which make it more difficult to tolerate the mentally ill in the *home, plus other factors which tend more* often to promote hospitalization in cities than in sparsely settled rural areas—nearness to clinics and hospitals multiple sources of medical attention etc Conversely *the identity of the rural prevalence* ratio with that of the entire country contraindicates any influence of the supposed differences between urban and rural living pressures in causing mental breakdown

C Mental Disorder and Age

Also clearly indicated in Table 17 is the association between prevalence ratio for mental disease and aging For the groups above age 40 the incidence rate per 1000 is almost twice the national average It should be noted that the census figures give only the rate for those affected with mental disorder at the time of the enumeration and therefore do not include any

patients had some complicating somatic disease and that one-half of these were cardiovascular disorders This fact suggests that the greater the numbers of aged in the mental hospital the greater will be the demands for general medical and surgical services if the challenge of these complicating physical conditions is to be met.

Sjogren (1954), in a survey of 3000 cases treated in the years 1940–51 in the women's department of Gothenburg's Lillhagen Mental Hospital, found that 25 per cent of all first admissions could be attributed to neuropsychiatric geriatric diseases

Figure 7 furnishes further documentation of the increasing demands made by older people upon the resources of Swedish mental hospitals In the period 1931–55 the proportion of first admissions over age 60 at *onset of disease* rose from 8 7 to 19 7 per cent for men and from 10 4 to 22 6 per cent for women While these figures are for the state hospitals and those of the three largest cities, this would comprise the great majority of the first admissions in the country

Sweden, however, has not felt up to this time that the mental health problems of the aged are uniquely urgent Dr Hans Curman, secretary of the Swedish Association for Mental Health, says that, in the past, gerontologic aspects of mental health have not been stressed but that the necessity for such emphasis in the near future is foreseen Should this emphasis be adopted as a part of the program of the association, its promulgation would be in highly effective hands, for the main work of this group has been the carrying-on of valuable educational work reaching professional and lay groups alike Particularly important

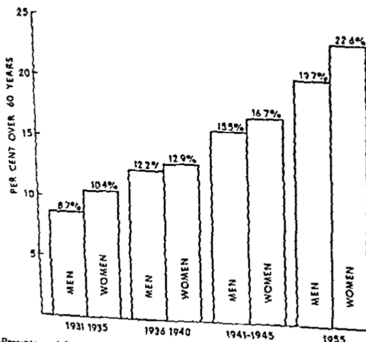


FIG 7 —Percentage of fi...
of Sweden ...
Larsson and ...
Population ...
Board *Pub* ...
[Stockholm ...

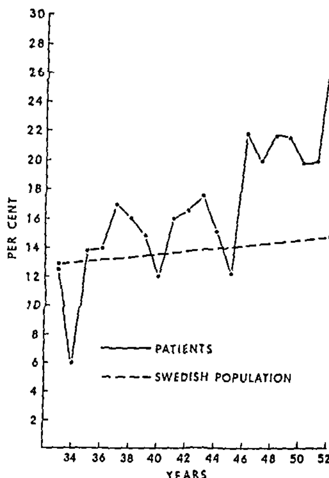


FIG 6 —Percentage of patients over age 60 of the total number of patients of St Lars Hospital and the percentage of the total Swedish population over age 60 for the years 1933–52 (After O Hagnell, "Psychosis in the Aged an Increasing Psychiatric Problem," *Nord Med*, **51** [1954], 738, Fig 2)

TABLE 19*

DISTRIBUTION OF AGED PATIENTS ADMITTED TO ST LARS HOSPITAL LUND, SWEDEN, DURING 1951–52 BY AGE AND DIAGNOSIS

Age	Senile Psychosis	Psychosis with Arteriosclerosis	Depressive Psychosis	Schizophrenia	Other	Total No	Total Per Cent
60–64	1	2	26	14	14	57	23
65–69	11	14	20	14	13	72	29
70–74	23	4	6	6	11	50	20
75–79	27	8	2	4	2	43	17 5
80–84	13	2			1	16	6
85–89	7					7	3
90–95	1					1	0 5
Total	83	30	54	38	41	246	
Per cent	34	12	22	15	17		100

* Source O Hagnell "Psychosis in the Aged an Increasing Psychiatric Problem *Nord Med* 51 (1954) 739

may be obtained by noting the share of capital resources available to regional hospital boards which has been allocated to mental and mental deficiency hospitals For the period 1948–56, of the total capital expenditure of these boards, 23 9 per cent was spent on mental institutions In 1955–56 it amounted to 34 3 per cent of total capital expenditures Of the more than $160 million (£58,309 747) allocated for England and Wales during the entire period more than $23 million (£8,311 586) was spent on mental hospitals and almost $16 million (£5 639 666) on mental deficiency hospitals (Great Britain, Ministry of Health, 1957*a*)

In general these capital expenditures have been made for the upgrading and modernization of existing hospitals Funds have been allocated by the Ministry of Health to improve ward layout and equipment, modernize catering arrangements and enhance equipment and treatment facilities (Great Britain, Ministry of Health, 1957*a*)

That a constant effort must be made to better and modify existing hospitals to meet present day patient loads and therapeutic demands is obvious in view of the great age of most hospitals The Minister of Health in his report for the year 1955 noted Most of the existing mental hospitals were built in the nineteenth century and the last new one was opened as long ago as 1933 so that though additions have been made to those already in existence most hospitals reflect the past insistence upon segregation of patients from the community either through their isolated situation or the height of the walls around them (Great Britain Ministry of Health 1956 p 124)

OVERCROWDING

In view of the above statement it is not surprising that overcrowding exists At the end of 1956 there were 138 215 patients in *designated mental hospitals*, but by 'recognized space standards" there was room for only 121 213 beds This meant that an average overcrowding of 14 per cent could be found throughout these institutions (Great Britain, Ministry of Health 1957*a*)

This figure, however, represents some improvement over previous years In 1955 overcrowding was estimated to be 14 8 per cent, in 1954 it was 15 6 per cent and in 1953 it had been 15 7 per cent Thus while a fairly substantial space deficiency exists if present trends continue considerable relief of this condition may be expected within a reasonable period of time (Great Britain, Ministry of Health, 1955)

Mental health authorities are not being stampeded into an all-out campaign to construct new hospitals to relieve the shortage of space, although some building to this end has been effected Rather the major objective is the reduction of the number of patients in mental hospitals by exploiting all possibilities for lessening the intake of new patients, shortening the stay of patients in hospital, and developing new methods of treating or caring for patients outside the confines of the traditional mental hospital As we shall see efforts in these directions have not been without success and current developments along these lines in Britain merit close attention

NURSING SHORTAGE

While a nursing shortage is said to exist, this apparently contributes in only a very small way to the bed deficiency At the end of 1954 there was an average of one nurse to every 6 6 beds in designated mental hospitals Although some dissatisfaction was felt with this ratio lack of staff accounted for the loss of only 765 beds which otherwise might have been in service in mental hospitals In order to rectify this condition, local recruitment campaigns for nurses were instituted in 1953, with most of the efforts being directed toward the recruitment of staff for mental and mental deficiency hospitals While immediate results were negligible, it was felt that long range effects will prove the effort worthwhile (Great Britain, Ministry of Health, 1955)

has been its work in building up a library of mental health films and promoting them throughout Sweden (Nyblaeus, 1956)

All in all, Sweden's great concern for the welfare of her aged, plus her imagination and willingness to meet the needs of this segment of her people, leads one to predict with confidence that no important aspect of the mental health of her aged subjects will long be neglected

VI United Kingdom[1]

Great Britain is acutely aware of the many problems which a modern, forward looking nation must solve in order to meet adequately the mental health needs of its citizens In Britain the satisfaction of these needs lies primarily within the province of the state operated health services in which mental health interests are but part of a many sided responsibility This means that expenditures of both money and energy in the field of mental health must be viewed as part of an integrated effort to maintain the health both physical and mental of the entire nation

Increasingly, the mounting numbers of aged is cause for special attention to be directed toward this segment of the population, but here again, with few exceptions geriatric problems are not singled out as being uniquely different from those of other age groups This approach, of course, has several advantages, the most conspicuous of which is the potential diversity of medical skill and facility which can be brought to bear upon mental and physical illness in the aged

SCOPE

In spite of administrative integration, mental health services remain a distinct sphere of activities and responsibilities within the state health services That their share of the burden imposed upon the nation's health resources is very large cannot be denied, but it is difficult to be precise We do know, however, that, of the 481,710 staffed hospital beds allocated to all departments of the National Health Service (England and Wales)[2] on December 31, 1955, a full 44 per cent were placed at the disposal of the mentally ill and the mentally deficient One third (157,870) of all these beds were for the mentally ill alone (Great Britain, Ministry of Health, 1957*a*)

This is, of course, only one way in which the impact of mental illness on the health services can be pictured If we consider the number of *different* inpatients treated during the year by mental and other hospitals, it becomes apparent that, because of the much lower turnover of mental patients, they are relatively far fewer than would be anticipated from the number of beds they occupy One indication of this low turnover may be obtained by comparing the average duration of stay by different types of patients In 1955 for selected hospital departments these durations (in days) were as follows general medicine, 22 2, general surgery, 13 7, obstetrics, 12 1, chronic sick, 172 5, mental deficiency, 4123 2, mental illness—LMTA,[3] 552 1, and mental illness—other, 103 9

These figures show clearly that, apart from the tremendous number of people under treatment for mental illness the long period of their hospitalization adds a unique dimension to this problem Since these comprise all but about 2 per cent of those receiving care, it is apparent that the mean duration of stay for the mentally ill patient is about 1½ years (Great Britain, Ministry of Health, 1957*a*)

COSTS

While the relative costs of mental illness are not readily available, some indication of the importance attached to the improvement and expansion of service in this area

2 Almost without exception the discussion in [illegible]

[illegible] Kingdom

3 The initials LMTA refer to those patients treated under the Lunacy and Mental Treatment Acts

may be obtained by noting the share of capital resources available to regional hospital boards which has been allocated to mental and mental deficiency hospitals For the period 1948–56 of the total capital expenditure of these boards 23 9 per cent was spent on mental institutions In 1955–56 it amounted to 34.3 per cent of total capital expenditures Of the more than $160 million (£58,309,747) allocated for England and Wales during the entire period, more than $23 million (£8,311 586) was spent on mental hospitals and almost $16 million (£5 639 666) on mental deficiency hospitals (Great Britain, Ministry of Health 1957*a*)

In general these capital expenditures *have been made* for the upgrading and modernization of existing hospitals Funds have been allocated by the Ministry of Health to improve ward layout and equipment modernize catering arrangements and enhance *equipment* and treatment facilities (Great Britain Ministry of Health 1957*a*)

That a constant effort must be *made to* better and modify existing hospitals *to* meet present-day patient loads and therapeutic demands is *obvious in view of the* great age of most hospitals *The Minister* of Health in his report *for the year 1955* noted Most of the existing mental hos [illegible]

[illegible] made to those already *in existence* most hospitals reflect the past *insistence* [illegible]

[illegible] of the walls around them (Great Britain Ministry of Health 1956 p 124)

OVERCROWDING

In view of the above statement it is not surprising that overcrowding exists At the end of 1956 there were 138 215 patients in *designated mental hospitals*, but by 'recognized space standards there was room for only 121 213 beds. This meant that an average overcrowding of 14 per cent could be found throughout these institutions (Great Britain, Ministry of Health, 1957*a*)

This figure, however, represents some improvement over previous years In 1955 overcrowding was estimated to be 14 8 per cent, in 1954 it was 15 6 *per cent* and in 1953 it had been 15 7 per cent. Thus while a fairly substantial space deficiency exists [illegible]

Mental health authorities are not being stampeded into an all-out campaign to construct new hospitals to relieve the shortage of space, although some building to this end has been effected Rather the major objective is the reduction of the number of patients in mental hospitals by *exploiting* all possibilities for lessening the intake of new patients shortening the stay of patients in hospital and developing new methods of treating or caring for patients *outside the confines of the traditional mental hospital As we shall see* efforts in these directions have not been without success *and current developments along these lines in Britain* merit close attention

NURSING SHORTAGE

While a nursing shortage is said to exist this apparently contributes to only a very small way to the bed *deficiency* At the end of 1954 there was an average of *one* nurse to every 6 6 beds in designated *mental hospitals* Although some dissatisfaction was *felt* with this ratio lack of staff accounted for the loss *of only* 765 beds which otherwise might have been in service *in mental hospitals* In order to *rectify this condition* local recruitment *campaigns* for nurses were instituted *in 1953*, with most of the efforts being *directed toward* the recruitment of staff *for mental* and mental deficiency hospitals While immediate results were negligible *it was felt* that long range effects will prove the effort worth while (*Great Britain* Ministry of Health, 1955)

NUMBER OF MENTAL PATIENTS

Table 20 gives the number of patients under treatment for mental disorder in England and Wales at the end of 1954 and 1956 Only those patients whose hospitalization was effected under the terms of the Lunacy and Mental Treatment Acts, 1890–1930, are included in this table Since, as we have seen above, more than 97 per cent of the mentally ill hospital patients are cared for under this act, Table 20 represents almost the entire mental hospital population

TABLE 20*

NUMBER OF PATIENTS UNDER TREATMENT FOR MENTAL DISORDER UNDER LUNACY AND MENTAL TREATMENT ACT (ENGLAND AND WALES) DECEMBER 31 1954 AND 1956†

	Voluntary	Temporary	Certified	Total
Male				
1954	16 350	100	48 345	64 795
1956	19 142	130	44 432	63 704
Female				
1954	21 014	243	66 092	87 349
1956	25,927	267	59 582	85 776
Total				
1954	37 364	343	114 437	152 144
1956	45 069	397	104 014	149 480

* Source Ministry of Health, *Report for the Year Ended 31 December 1954* (London H M Stationery Office 1955) Table A and Ministry of Health *Report for the Year Ended 31 December 1956* (London H M Stationery Office 1957 Table A

† Does not include mental deficiency

Perhaps the most significant fact presented in this table is the slight but still perceptible decrease in the total number of patients under treatment at the end of 1956 when compared to the same period in 1954 In 2 years time a drop of 2664 patients was experienced in these hospitals This fact is the more interesting when viewed in the light of the information contained in Table 21, which shows that during this same period the number of direct admissions increased from 76,650 to 88,542 patients Thus, even though 11,892 more patients came in in 1956, the total number of patients in the mental hospitals at the end of the year was 2664 less than at the end of 1954 It is obvious that this reversal is not then the result of any slackening in the trend toward increases in the numbers of the mentally ill but must be explained by procedural and therapeutic changes within the hospitals themselves

VOLUNTARY TREATMENT

Under the Lunacy and Mental Treatment Acts, 1890–1930, patients who make valid written application for treatment in mental hospitals "designated" under the provisions of those acts may be received as voluntary patients These statutes also make provision for the compulsory admission of patients under procedures now known as certification which "were introduced from the late eighteenth century onwards to authorize the detention of patients in institutions hospitals and private homes" (Great Britain, Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1957, par 255) At the time these laws were first introduced they were thought of primarily as safeguards to prevent the unwarranted detention of sane persons

The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957) devoted an important share of its energies to the consideration of the

various problems associated with certification Criticism of this legal procedure was twofold (1) that certification itself has decidedly ill effects upon both the patient and his relatives and (2) that some individuals who are not of "unsound mind" are improperly detained While the great bulk of the testimony received was directed at the former the implications of the latter seem to refer more specifically to the situation of the infirm aged and senile person The facts behind this criticism are not particularly sinister but relate to the commonly accepted practice of obeying as mandatory a judicial order to admit a patient

CERTIFICATION OF AGED

With the abandonment of the poor law in 1948 the power to order infirmaries and institutions operating under that law to receive the senile aged was lost. Evidence placed before the Royal Commission led it to report

> As a result at a time of general shortage of accommodation greater pressure can now be brought to bear on mental hospitals to admit a patient provided he is of unsound mind than on other hosp tals or residential homes There is some evidence that th s has contributed to a tendency to use the compulsory powers contained in the Lunacy Acts to admit to m
>
> atn hom dist bef wel ... it may well be that the mental ho pital is the best place for some such patients but we *consider it* an abuse of compulsory powers to use them as a form of pressure on one particular type of hospital only to admit patients who could be equally well cared for elsewhere [*Great Britain Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1957* par 239]

In other sections of the report it is emphatically stated that the commission received no evidence to support the allegation that old people not suffering from mental disturbance or deterioration were being admitted to mental hospitals Nor did the commission support the view that old people should not be sent to mental hospitals, for, in its opinion, the aged could benefit from the skilled attention that could be offered in these institutions It did, however, think it wrong to admit individuals who could not be helped by hospital treatment or to retain others fit enough to leave simply because there was nowhere else to go It was felt, *nevertheless*, that this was often the case

TABLE 21*

Status	1951		1956	
	No	Per Cent	No	Per Cent
Voluntary	55 270	72 1	69 479	78 5
Temporary	1 173	1 5	1 504	1 7
Certified	20 256	26 4	17 559	19 8
Total	76 650†	100 0	88 542	100 0

* Source ...

† Does not incl ...

The commission recommended that, *while* compulsory powers should be retained *for* restricted use when necessary, all hospitals should be free to admit patients informally Certain procedural changes were recommended ... the ... The ... would fall into disuse along with all its derogatory connotations

While it had been *argued that* different procedures should be applied in the admission of senile *patients* the commission did not think it desirable for any one age group

of patients or for any one form of illness or deterioration to be dealt with in a special manner Specifically, the commission felt that the law should not prevent a mentally ill patient from entering the hospital informally (i e, without being *subject to* detention), even though he may not be able to make valid application as required by the Lunacy Act It should be assumed that he is content to enter the hospital for treatment unless he positively objects Patients who are admitted voluntarily or informally should not be required to sign admission papers or *to give formal notice* of intention to leave

TABLE 22*

Average Annual Increase (or Decrease) by Status of Patient 1952 56 Inclusive *(England and Wales)*

Status	Average Annual Increase or Decrease		
	Total	Male	Female
Voluntary	3184	1276	1908
Temporary	10		10
Certified	−2912	−1131	−1781

* Source Ministry of Health *Report for the Year Ended 31 December 1956* (London H M Stationery Office 1957) Table A

RISE IN VOLUNTARY ADMISSIONS

In essence the commission aimed at liberalization of the law and at bringing its provisions *in line with modern therapeutic* principles and practices Inspection of Ta*bles 20, 21, and 22 will show that,* even under the Lunacy Acts, a very high, and *growing,* percentage of patients are classified as voluntary Between 1954 and 1956 *the proportion of voluntary patients in* England and Wales increased from *25* to *30 per cent of* the total under treatment (Table 20) In 1954, 72 1 per cent of all *admissions* were *voluntary,* and by 1956 this had increased to 78 5 per cent (Table *21) That this* trend is stable is indicated in Table 22, which shows that for the period *1952–56 there* was a mean annual increase of *3184* voluntary patients under treatment in England and Wales and a mean annual decrease of 2912 certified patients

PRIVATE PATIENTS

Most mental patients in England and Wales are cared for under provisions of the National Health Service, but a small percentage of the total are private patients At the end of 1956, of the 149,480 patients under treatment, 4086 were classified as private patients While most of the latter were in mental hospitals vested in the Ministry of Health, almost equal numbers were in registered hospitals, and much smaller numbers were distributed in various other kinds of accommodation, such as licensed houses, nursing homes, naval and military hospitals, and private single care (Great Britain, Ministry of Health, *1957a*)

MOVEMENT OF PATIENTS

Table 23 gives an analysis of mental hospital admissions and discharges in England and Wales for 1956 These figures show a drop in the number of patients in residence during the year from 150,856 on January 1 to 149,480 on December *31* While this is a very slight decrease in total number of patients, it assumes considerable *significance when viewed as a part* of the continued reduction in the number of patients already referred to above

Table 24 complements Table *23* in that it relates the status of the discharged patients (i e, whether voluntary, temporary, or certified) to the degree of improvement effected during hospitalization The cases enumerated in the two tables are the same with the exception that patients discharged from three institutions included in Table 23 are deleted from Table *24* Superficial examination of the latter table might lead one to conclude that chances of recovery are unrelated to status or even that certified patients had a slightly better chance of recovery than voluntary patients that is,

25.4 per cent recovery for voluntary patients versus 33.3 per cent for certified. Closer inspection of the data, however, reveals the error of this impression, for these percentages refer only to the rate of recovery of discharged voluntary and of certified patients considered as separate groups. When one takes into account all discharged patients during the year, it is apparent that the great majority (86.3 per cent) have voluntary status. Considering the facts, as given above, that voluntary patients comprise 30 per cent of the patients under treatment and 78.5 per cent of all admissions, the favorable position of this group as regards recovery seems obvious. In fact, the number of voluntary patients discharged as *recovered* alone exceeds the entire number of discharged certified patients in 1956.

TABLE 23*

MOVEMENT OF MENTAL PATIENTS: SUMMARY OF ADMISSIONS, DISCHARGES, AND TRANSFERS FROM ONE FORM OF CARE TO ANOTHER AND DEATHS DURING 1956

	Total	Males	Females
Resident on January 1, 1956	150,856	64,339	86,517
Direct admissions			
Total	88,542	36,211	52,331
Not previously admitted	50,405	21,221	29,184
Other	38,137	14,990	23,147
Indirect admissions	781	384	397
Total	240,179	100,934	139,245
Discharged and departed			
Total	76,481	31,230	45,251
Recovered	20,237	7,555	12,682
Relieved	47,742	19,508	28,234
Not improved	8,109	3,962	4,147
By operation of law	393	205	188
Transferred (under order) to other care	877	436	441
Died	13,341	5,564	7,777
Remained at December 31, 1956	149,480	63,704	85,776
Total	240,179	100,934	139,245

* Source: Ministry of Health, *Report for the Year Ended 31 December 1956* (London: H.M. Stationery Office, 1957), Table B.

TABLE 24*

ANALYSIS OF DISCHARGES FROM MENTAL HOSPITALS, ENGLAND AND WALES,† BY STATUS AND CONDITION ON DISCHARGE

	No.	Per Cent Recovered	Per Cent Relieved	Per Cent Not Improved	Total
Total	71,990	26.4	63.3	10.3	100
Voluntary	62,106	25.4	63.8	10.8	100
Temporary	371	33.1	58.5	8.4	100
Certified	9,513	33.3	60.0	6.7	100

* Source: Ministry of Health, *Report for the Year Ended 31 December 1956* (London: H.M. Stationery Office, 1957), Table B.

† Excluding Bethlem and Maudsley hospitals and Broadmoor Institution.

A Geriatric Problems of the Mental Hospital

While recent annual reports of the Ministry of Health do not give a complete age analysis of patients under treatment, some information on age structure is given in specific research reports on single hospital populations or on groups of hospitals We know, however, from the *Survey of Services Available to the Chronic Sick and Elderly, 1954–1955*, that 30 per cent of the residents under treatment in mental hospitals at the beginning of 1955 were aged 65 or over and that 20 per cent of the new admissions were in this age group (Boucher, 1957)

In 1938, however, only 17 5 per cent of the population of former county and borough mental hospitals was over this age By 1948 this proportion had risen to 23 9 per cent of the total population This age group is thus considerably overrepresented in the hospital population, for in 1938 only 8 7 per cent of the total population of England and Wales were older than 65, by 1948 this had risen to 10 8 per cent and reached 11 42 per cent in 1954

Early in 1952, Cook, Dax, and Maclay (1952) published in the *Lancet* a study of the geriatric problem in mental hospitals This investigation has more than passing significance because it had appeared earlier in a somewhat different form, as a report of an *ad hoc* Geriatric Committee to the Royal Medico psychological Association The existence of this report indicates the concern of this body with the psychiatric problems associated with the aged mental patient

These investigators point out that, because of conditions related to World War II, the total mental hospital population fell by 3135 patients between 1938 and 1948 This situation was largely brought about by the loss of hospital beds during this period In spite of the decrease in the over all number of patients, the age group above 65 years increased by 7674 persons This resulted in a fall of 10,809 patients under age 65, which could not be accounted for by lack of suitable patients in this age group The reason for this relates to the custom, already referred to above, of interpreting certification as a mandatory order to admit patients to hospital Hospitals were, therefore, forced to turn away voluntary patients in order to take those who were certified, and these tended increasingly to fall in the aged, senile group It was to prevent exacerbation of this situation that the recommendations of the Royal Commission concerning certification were made (see above)

This was not felt, however, to be the only reason for the rise in the age of the hospital population Diminished accommodation in special institutions for the aged and less facilities for the care of the aged in the community were also considered contributing factors It was estimated that in the Southwestern Metropolitan Region (London), with a mental hospital population of 10,200, 743 (25 per cent) of the 2991 patients over age 65 could be cared for in institutions other than a mental hospital This number is 7 3 per cent of the mental hospital population of the entire region In the Southeastern Metropolitan Region in 1948 the proportion of the aged in mental hospitals who could be cared for in geriatric beds or beds for the chronic sick was estimated to be even higher

In addition to the above familiar reference is made to altered social conditions which decrease the number of families willing or able to take care of the chronically ill aged in the home It was felt that many aged mental patients could be discharged if there were a woman relative at home to care for him or her but in England as elsewhere in western Europe, this condition is more difficult to meet today than formerly

DISCHARGE, DEATH, AND AGE

Cook and his associates (1952) followed the history of all the patients over age 65 admitted to six mental hospitals during

1947 The disposition of these cases over a 2 year period is shown in Table 25 The total capacity of the six study hospitals was about 11 500 beds, and the 510 patients over age 65 admitted to them in 1947 represented 7 per cent of all patients in this age group admitted to the mental hospitals of England and Wales in 1947

TABLE 25*

FATE OVER A 2-YEAR PERIOD OF PATIENTS AGED 65 AND OVER ADMITTED TO SIX MENTAL HOSPITALS 1947

Fate	Male		Female		Total	
	No	Per Cent	No	Per Cent	No	Per Cent
Total admissions in 1947	167	100	343	100	510	100
After 6 weeks						
Dead	45	27	50	14	95	19
Discharged	20	12	27	8	47	9
Remaining	102	61	266	78	368	72
After 6 months						
Dead	60	36	86	25	146	29
Discharged	42	25	118	34	160	31
Remaining	65	39	139	41	204	40
After 1 year						
Dead	0	42	101	29	171	33
Discharged	52	31	140	41	192	38
Remaining	45	27	102	30	147	29
After 2 years						
Dead	80	48	120	35	200	39
Discharged	60	36	148	43	208	41
Remaining	27	16	75	22	102	20

* Source L C Cook F C Dax, and W S Maclay "The Geriatric Problem in Mental Hospitals" *Lancet* February 23 1952 pp 377-82

The ratio of men to women admitted to the six hospitals was 1 2 03 while for all admissions in England and Wales in 1947 [illegible] ... [illegible] higher At the end of two years only 70% [illegible] ... [illegible] throughout the period the women maintained a higher rate of discharge and a lower death rate (Cook *et al* 1952 pp 378–79)

In Tables 26 and 27 and in Figure 8 discharge data are given on admissions to English and Welsh mental hospitals for the period 1952–57 The picture presented by the Cook data and the picture in Table 27 are not conflicting although the latter shows a higher rate of discharge for aged patients Whether this is actual or artifactual is difficult to ascertain, however, it is quite possible that it may reflect the shift apparent in Table 26 Here a slight but noticeable trend in the direction of the early release of patients can be observed in the triennium 1952–54 As may be seen in this table 72 7 per cent of all patients admitted to designated hospitals during 1952 were released within 12 months. This number was increased by about 2 per cent in 1953 and by an additional 2 per cent in the following year so that in 1954 a total of 76 7 per cent of admissions were released within a year of their entrance into hospital

If we consider only patients under the age of 65 at the time of admission, early release has remarkably little relationship with age Figure 8 shows graphically how

closely clustered are the four age groups under age 65, while those over age 65 trail behind with scarcely more than half the rate of release at each of the selected intervals Yet here, too, the percentage is not inconsiderable—indeed, it is surprisingly large—for more than two out of every five patients over the age of 65 admitted during 1953 were released within the year

Just as the discharge rate was highest during the first 6 months, inspection of Table 25 shows that death rate is also high during this period and in fact is particularly high during the first 6 weeks Thus, in this series, within 6 weeks after admission to a mental hospital approximately one out of every five patients over the age of 65 died If we calculate the ratio of deaths expected for the general public to those occurring in this age group within 6 weeks of admission, we find a ratio of 1 24 which means that for every death expected in the general public twenty four would be expected in this particular group during this limited time Thereafter, this ratio improves markedly, from 6 weeks to 6 months it is 1 3 8 and progresses to 1 1 3 for the next 6 months (Cook *et al*, 1952)

B Recommendations

1 *Short stay units*—This experience with both death and discharge rates led Cook and his associates to recommend the establishment of short stay units to receive and retain patients for the period in which the greatest number of deaths and discharges occur They feel that these units should not be larger than about twenty five beds and should be attached to the geriatric

TABLE 26*

PATIENTS ADMITTED TO MENTAL HOSPITALS ENGLAND AND WALES † DURING 1952 1953 AND 1954 ANALYZED BY LENGTH OF STAY ON DISCHARGE

Year of Admission	Total No of Admissions	Percentage of Year's Admissions Discharged within—							Total No of Discharges (12 Months)
		1 Week	1 Month	2 Months	3 Months	6 Months	9 Months	12 Months	
1952	62 258	3 7	20 8	38 9	49 8	65 0	70 1	72 7	45 234
1953	67 422	4 0	22 5	41 6	52 5	67 4	72 2	74 8	50 414
1954	71 699	4 3	23 8	43 9	54 9	69 3	74 2	76 7	54 979

* Source Ministry of Health *Report for the Year Ended 31 December 1956* (London H M Stationery Office 1957) Table B
† Excluding Bethlem and Maudsley hospitals and Broadmoor Institution

TABLE 27*

PATIENTS DISCHARGED WITHIN 12 MONTHS OF ADMISSION FROM AMONG ADMISSIONS DURING 1953 TO DESIGNATED MENTAL HOSPITALS ENGLAND AND WALES†

Proportion of Patients Admitted in 1953 who were Discharged within—	Age					All Ages
	Under 16	16–24	25 54	55 64	65 and Over	
2 months of admission	37 8	40 6	48 4	42 0	22 9	41 6
3 months of admission	49 7	51 2	60 4	53 9	29 8	52 5
6 months of admission	72 0	73 0	76 5	68 4	38 7	67 4
12 months of admission	82 4	84 0	84 3	75 3	43 8	74 8

* Source Ministry of Health, *Report for the Year Ended 31 December 1956* (London H.M Stationery Office 1957) Table I
† Excluding only naval and military hospitals and patients in single care

section of larger general hospital centers The optimum period of stay should be from 6 weeks to 6 months with the mean length of residence of about 3–4 months

2 *Long stay units* —For most of the patients who remain after the expiration of the time limit set on the short-stay units transfer to larger units (two hundred beds or more) associated with general or psychiatric hospitals would be effected This type of accommodation would be under the clinical supervision of a psychiatrist but would serve the somewhat confused, amnesic senile person rather than chronically noisy patients or those likely to be disturbing to others While most patients would be admitted from the short stay units, some undoubtedly would enter directly

3 *Temporary measures* —Because of high costs, the *ad hoc* committee did not believe that its suggestions could be imple

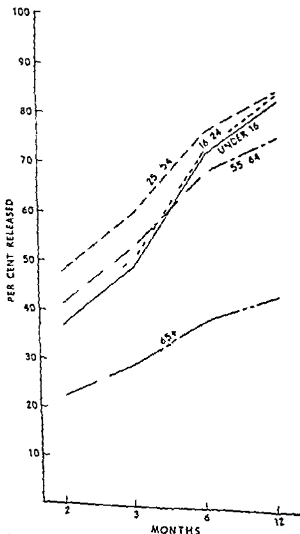


FIG 8 —Patients discharged with
in England and Wales in 1953
Part II (London H.M Stat on

mented immediately and, in view of this, offered alternative suggestions Considering the urgency of the situation the committee felt that as a temporary measure the mounting demands for mental hospital service from the aged should be met by putting the maximum number of beds possible in old people's wards even though it caused overcrowding This step was clearly recognized as *retrogressive, but the gravity of* the situation was felt to be ample justification The committee points out that such a move was economical, it costs less to treat sixty patients in two rather than in three wards If forced to overcrowd, the senile patient was the least likely to be affected, they are more resistant to common infectious illnesses, and their narrower *interests and restricted movements made* them less demanding of space

A similar attitude of resignation was expressed by Clark (1956) in an article describing, among other functions of the mental hospital, the place of geriatrics in English psychiatric institutions The mental hospital, he said, functions as a geriatric hospital largely by default of other *agencies The confused and ill aged are* brought to the mental hospital, "always unwillingly," where after a bit they settle down In not too long a time a fair proportion die, while some recover but have no place to go He continues

best to meet this demand by providing pleasant wards, good food kindliness and good physical nursing to ease the last days of these unfortunate people But the work absorbs a great deal of their limited time [p 1005]

This expression immediately drew a sharp attack from J A R Bickford medical superintendent of De la Pole Hospital York, who believes that aged patients should be treated in a well organized geriatric unit but who recognizes that these are in short supply He asks why senile patients should be sent to mental hospitals rather than to general hospitals? Why is *it more improper for a general hospital to* be overcrowded than a mental hospital? His answer goes immediately to the practice of certification as applied to old people, and his criticism is the same as that of the Royal Commission reported above Old people, he says, can be ordered to the mental hospital, and thus overcrowding is legalized "For some strange reason the *walls of a mental hospital are thought to* be capable of infinite expansion, and the agreement on this between the community and its elected and paid representatives in local and central government is universal (Bickford, 1956)

C The Chronic Mental Patient

Bickford's opinion was an *informed one* based not only upon his hospital experience but upon specific study of the problem (Bickford, 1954) Of some 450 men at De la Pole Hospital, other than those on admission and convalescence wards, 384 had been in the hospital for periods shown in Table *28*

TABLE 28

NUMBER OF YEARS STAY IN HOSPITAL FOR 384 MEN

Years	No
2 4	63
5 9	87
10 14	46
15–19	63
20–24	37
25–29	38
30 39	29
Over 40	21
Total	384

Why, he asks are the results so bad? *Basically, he believes the reasons to be* twofold psychiatrists are spread too thinly in the chronic wards and not enough money is *allocated for mental hospitals* The doctor in the chronic wards will have *hundreds rather than tens of patients* In *1954* the cost per week for a mental patient was likely to be not more than $14 (£5), while for the general patient it would usual

ly be $28 (£10) per week and more in sanitoriums and maternity hospitals Of this sum $5 60 (£2) would have been set aside for medical treatment for general hospital patients but only $0 56 (4 shillings) for mental hospital patients

Bickford is also critical of the physical conditions and standard of living of patients in chronic wards—lack of privacy limited space, inadequate activity programs and other conditions all too commonly associated with mental hospitals in all countries These conditions are contrasted with those which greet the newly admitted patient. These receive the best of treatment and are assigned to modern well fitted comfortable wards However if the patient

a chronic patient.

In bleak chronic wards psychiatric attention will be relatively less frequent Doctors will see 30 patients on admission wards for half their time and perhaps 200 chronic cases for the other half Or perhaps one physician will spend full time looking after 30 patients in admission wards while a colleague will attend 400–500 chronic patients Bickford does not believe that new admissions need the disproportionate amount of time given them

way by introducing marked changes in the therapeutic regimen in his own hospital

Behind these changes and the urgency in making them is the belief that remission can be expected in most chronic mental disorders as a part of the natural history of the disease Included in these expectations are both the schizophrenic and the senile patient. Remission in the case of the former may take anywhere from 10 to 50 years but Bickford has faith that it will occur, therefore he believes that

in preparation for his return to society While these may persist, the patient may learn to behave in such a way that he need not be kept hospitalized Even the restless, violent senile rarely remains this way for more than several weeks Bickford believes that he, too, can be returned to the community sometime after this initial phase

Although notable efforts are made to increase the livability of the ordinary chronic ward these are too often shallow and without deeply felt therapeutic objectives Occupational therapy, social clubs, frequent entertainment, games to watch and play, excursions, and instruction in painting and sculpture, while basically good are in danger of becoming ends in themselves Bickford believes that this is particularly true of occupational therapy, which can under such circumstances become, from the point of view of treatment "quite meaningless and absolutely useless"

All hospitalization must aim at fitting patients for discharge, never allowing them to adopt the attitude that they may remain indefinitely Chronic patients, too, must be fitted to return to home and work To achieve this end an active and imaginative program for chronic patients was set up at the De la Pole Hospital characterized by meaningful group activity Instead of assigning the majority of patients to useless cleaning duties they were cleared from the wards morning and afternoon to take part in planned therapeutic activities leaving the actual ward work to a small crew of co-operative patients to whom this work offered a realistic challenge Non-co-operative and hallucinated patients also went to work in groups and were given definite objectives Week-end visits home were instituted in order to give the patient (and his relatives) experience in living outside the hospital Within 6 months every patient in these chronic wards was receiving some active treatment every day

WIDESPREAD USE OF NEW APPROACH

The De la Pole Hospital experience is not an isolated one In 1955 the Ministry

of Health reported that, in addition to the development of new physical and chemical therapies, as well as psychotherapy, there had been a revival of interest in social re-education which had been "equally important for the long stay patient" This approach has been incorporated into the concept of the *therapeutic community*, and this in turn has become the goal toward which many hospitals are oriented More and more hospitals are adopting 'techniques of habit training as the first step in the rehabilitation of the more chronic and deteriorated patients (Great Britain, Ministry of Health, 1956)

UNLOCKING THE WARDS

Creation of the therapeutic community is hampered by the locked wards and security precautions traditionally associated with mental hospitals The unlocking of these doors is a major convulsion through which the hospital must go to achieve fully the permissive atmosphere sought in hospitals aspiring towards this goal

'On June 5, 1956, I opened the last closed ward at Hatton, so that now any of our 1,380 patients is free to walk out of the place if he wants to do so' writes Medical Superintendent E S Stern (1957) of the Central Mental Hospital in Hatton In this hospital there is no main gate to be locked and no porter there to guard it if there were

Hatton is not a special hospital for it shares the problems faced by ordinary British mental institutions—overcrowding a shortage of nurses but fortunately a low staff turnover, and an unselected group of patients The process of opening wards was a gradual one carried out largely on the initiative of the superintendent It depended upon educating the staff and securing their co-operation No wards were opened until the staff was ready to accept the idea As the program gained momentum it gained supporters, and instances arose in which the ward staff requested the unlocking of doors with no prompting from above

The most difficult wards to open were those for senile and demented patients who were likely to wander off and get lost The only serious accident, in the early phases of this experiment, was with one of these patients Liberation of the wards is bought at the expense of greater attention paid and interest given to the patient With greater freedom, patients leave the wards to spend time in more congenial places and thus indirectly relieve to some extent over crowding

Hatton is not unique, other hospitals are completely open, and many have only a few locked wards While there are problems associated with this liberal practice, escape from hospital is not a major difficulty Many hospitals report that patients seem to have less desire to escape when free to do so

D Future Hospital Planning

The influence of these new concepts of treatment and of mental hospital function is being felt in the planning for future British mental health needs If patients can be rehabilitated and if the community is willing to accept mental patients as it does other sufferers then the segregation of the mental hospital from the community is unnecessary and undesirable The British people seem to accept this generalization as an abstract principle but there is some hesitancy when it is applied or perhaps toward the way in which it is applied In Bristol for example plans to use a large residential dwelling as a hostel for selected adult mental defectives had to be abandoned because of protests of residents of the neighboring area who feared that potential child molesters would be included in the patient group This objection was not considered as a final deterrent to the project but it led to exploration of new locations

Nevertheless current thinking rejects the isolation and segregation which have characterized the treatment of the mentally ill in the past Most mental hospitals in Brit

ain were built during the last century and reflect in their isolated locations or their fortress like structure the then prevailing views toward mental illness These attitudes cut both staff and patients from the community and in and of themselves were damaging both to the patient s well being and to the quality of professional care he received. The large tracts of land once thought indispensable are no longer considered necessary This change should enable new b

i try of Health 1956)

But the building of new hospitals does not loom as the central core of Britain s mental health planning Where building is needed more often it will take the form of short stay psychiatric units of general hospitals. Provision of special geriatric units should lessen the need to expand facilities for the care of chronic patients in mental hospitals. The possibilities for discharging aged patients after treatment will be explored and expanded The most promising development however is the way in which the mental patient is being *reached with* treatment and service in the community itself

E Community Services

Recognizing that successful treatment of the mental patient involves co-operation among the hospital the family and the community in a growing number of instances community health services and mental hospitals have integrated their efforts in treating the mental patient. At Oldham for example a city of over 120 000 population in the industrial Midlands all patients with mental disorder are seen by a psychiatrist acting for both the regional hospital board and the local health authority before or instead of being sent to mental hospitals Day hospital services and a mental health team including the services of a clinical psychologist are available At Nottingham the superintendent of Mapperley Mental Hospital supervises the mental health service of the local health authority and is helped by a team of social workers drawn from both the staff of the hospital and the local health authority Instances abound in which the mental hospital staff and the local authority co-operate in the treatment of individual patients

F Treatment

Mental patients may be divided into three types those who may be treated outside the hospital those who need only a short period of hospitalization and finally, those who may be expected to remain in hospital for a long period of time The well-organized mental health service attempts to satisfy the therapeutic demands of all three groups with appropriate procedures and facilities To hospitalize patients who could be treated as outpatients or to retain patients in hospital beyond the requirements of their treatment not only may be uneconomical but also may be detrimental to the patient. In England and Wales the attempt

peutic advantages for the patients

1 *Outpatient treatment*—The outpatient method of dealing with mental patients is becoming increasingly popular attendance as psychiatric outpatient clinics rose from 523,218 in 1950 to 714,014 in 1955, increasing the following year to 762 072 These measures not only have served to reduce admission rates but, in addition have hastened the return of the hospitalized patient to the community—not to speak of the advantages to the patient, who is spared the difficult transitions into and out of hospital (Great Britain, Ministry of Health 1956, 1957*b*)

2 *Domiciliary visits*—In view of our earlier discussion of work being carried out in the Netherlands it is interesting to read the following in the 1956 annual report of the Chief Medical Officer for England and Wales

of Health reported that, in addition to the development of new physical and chemical therapies, as well as psychotherapy, there had been a revival of interest in social re education which had been "equally impor tant for the long stay patient" This ap proach has been incorporated into the con cept of the *therapeutic community*, and this in turn has become the goal toward which many hospitals are oriented More and more hospitals are adopting 'tech niques of habit training as the first step in the rehabilitation of the more chronic and deteriorated patients (Great Britain, Ministry of Health, 1956)

UNLOCKING THE WARDS

Creation of the therapeutic community is hampered by the locked wards and se curity precautions traditionally associated with mental hospitals The unlocking of these doors is a major convulsion through which the hospital must go to achieve fully the permissive atmosphere sought in hos pitals aspiring towards this goal

"On June 5, 1956, I opened the last closed ward at Hatton, so that now any of our 1,380 patients is free to walk out of the place if he wants to do so," writes Medical Superintendent E S Stern (1957) of the Central Mental Hospital in Hatton In this hospital there is no main gate to be locked and no porter there to guard it if there were

Hatton is not a special hospital, for it shares the problems faced by ordinary British mental institutions—overcrowding a shortage of nurses but fortunately a low staff turnover, and an unselected group of patients The process of opening wards was a gradual one carried out largely on the initiative of the superintendent It depended upon educating the staff and securing their co-operation No wards were opened until the staff was ready to accept the idea As the program gained momentum it gained supporters, and instances arose in which the ward staff requested the unlocking of doors with no prompting from above

The most difficult wards to open were those for senile and demented patients who were likely to wander off and get lost The only serious accident, in the early phases of this experiment, was with one of these patients Liberation of the wards is bought at the expense of greater attention paid and interest given to the patient With greater freedom, patients leave the wards to spend time in more congenial places and thus indirectly relieve to some extent over crowding

Hatton is not unique, other hospitals are completely open and many have only a few locked wards While there are prob lems associated with this liberal practice escape from hospital is not a major diffi culty Many hospitals report that patients seem to have less desire to escape when free to do so

D Future Hospital Planning

The influence of these new concepts of treatment and of mental hospital function is being felt in the planning for future British mental health needs If patients can be rehabilitated and if the community is willing to accept mental patients as it does other sufferers then the segregation of the mental hospital from the community is unnecessary and undesirable The British people seem to accept this generalization as an abstract principle but there is some hesitancy when it is applied or perhaps to ward the way in which it is applied In Bristol for example plans to use a large residential dwelling as a hostel for selected adult mental defectives had to be aban doned because of protests of residents of the neighboring area who feared that po tential child molesters would be included in the patient group This objection was not considered as a final deterrent to the project but it led to exploration of new locations

Nevertheless current thinking rejects the isolation and segregation which have char acterized the treatment of the mentally ill in the past Most mental hospitals in Brit

quick transition to inpatient care should th s become necessary

3 *Geriatric day hospitals* —Much seem ingly irreversible mental disorder in the aged results from the deterioration of per sonal habits and living standards induced by physical frailty Failure to receive some attention and help during the day leads to such a stage of delapidation that mental hospitalization always against their will is forced upon the ail ng aged person as a last resort Once in hospital the family, if there is one rarely seems able to accept the patient back To meet the needs of such patients the Cowley Road Day Hospital Oxford was established (Cosin 1954)

This unit a proved success was set up as a part of a general geriatric service rather than being made an exclusive psy chiatric responsibility Each patient how ever receives attention for both his physi cal and his mental needs To insure this he is given what Dr Cosin calls a dynamic quadruple assessment this includes a

t es This is done in order to achieve as complete rehabilitation as is possible

As would be expected the Oxford unit has close hospital links for both inpatient and outpatient treatment It is under full medical control with consultant psychia tric advice It aims to maintain the patient in the community living independently To achieve this the day hospital shares re sponsibility for the patient with the family and the community on the well founded as sumption that frail aged people are hos pitalized permanently because of the in ability of the family to take complete 24 hour a day care of the patient By sharing the load with the family the patient may be maintained outside the hosp tal with greater happiness for himself and at less expense to the community

Mr. t. a

a above. The decision to accept the day hospital patient after discharge as an inpatient is made in staff conference by the clinician the psychiatrist the medical social worker, and the superintendent oc cupational therapist However, not all pa tients come from the hospital for some are referred directly by the general practition er Close relationships are maintained with the department of physical med cine be cause many old mental patients suffer from painful physical disability Treatment avail able through this department is particular ly important for the confused patient who has suffered from a cerebrovascular ac cident.

Patients are brought to the day hospital from their own homes by transport pro vided by the local authority or by a vol unteer hospital car service and are col lected in the same way at the end of the day Not all patients come every day or even for full days the number of days at tendance being determined by individual needs

Some patients are assigned to physio therapy before taking part in occupational therapy which may be prescribed on an individual or a group basis Group work may not be advisable for all patients with chronic anxiety states or affective psychosis are often given a small corner and quiet, uncomplicated work to do The occupa tional therapist gives reassurance and sup port to all The medical social worker may interview the patient while he engages in occupational therapy rather than in the of fice This approach supplants the hurried interview with the physician or social work er in more formal surroundings

4 C

scrutiny An example is the Marlborough Day Hospital where groups of short and long stay pa tients are accepted and where an outpatient service is offered to both adults and chil dren Physical treatment is given in addi tion to group and individual psychotherapy The addition of a night hospital to such a

> The value of domiciliary visits has been much extolled in recent years especially as a result of the work of Dr Querido in Amsterdam Clearly it is an advantage for the psychiatrist to see the patient in his own surroundings and to be able to assess for himself what is happening in the home, this may well indicate a line of treatment which would not be apparent in the consulting room [Great Britain Ministry of Health 1957b]

This accolade does not presage the uncritical adoption of the Amsterdam plan but it does indicate a willingness to examine the relative merits and disadvantages of the system Reservation concerning costs in money and time is expressed but a wait and see attitude is adopted Meanwhile the number of domiciliary visits or house calls increases—from 5597 in 1950 and 11 229 in 1955 to a 1956 total of 18 416 (Great Britain, Ministry of Health 1956, 1957b)

G Day Hospitals

Some patients if occupied and supervised during the day, can remain in the home during the evening and at night others may be able to work or look after themselves during the day but need care and attention at night Neither group needs full time hospital care and it is for them that so called day hospitals and night hospitals have been developed Experience with these has been favorable and in 1956 there were seventeen in England and Wales with more being planned (Great Britain Ministry of Health, 1956)

Two factors of importance must be considered in the establishment of day hospitals location and administrative control Ideally, the day hospital should be placed where it can be easily reached by the patients it serves thus it must be in a central urban area serving a *catchment district* which, according to British thinking should not extend more than 5 miles in any direction from the hospital The second point somewhat controversial, is whether the day hospital should be associated with a mental hospital or should be entirely separate The advantage of the former in terms of making available trained staff and facilities is obvious but the forbidding association with the mental institution makes acceptance of this form of treatment more difficult for some patients

For the simple geriatric day hospital independent operation is seen as having no special disadvantage, however, more comprehensive centers require more specialized staff and facilities If the independent unit attempts to meet all these needs, its character changes, and its costs of operation mount It is felt, however, that the value of the day hospital to both the community and the mental health service is dependent upon the simplicity of its function and that these functions can be met by four different types of services *day centers, day hospitals, geriatric day hospitals*, and *comprehensive day hospitals* All these are small the number of patients it seems should not number more than thirty

1 *Day centers*—These centers would be concerned primarily with aftercare of mental hospital patients and with their rehabilitation Individual and group psychotherapy might be offered social activities would be fostered through organized social clubs and other activities Although its main function is to ease the transition from inpatient life to normal community living some neurotics might be treated at the center The Bromley Day Hospital has experimented with the introduction of a very few disturbed patients with the convalescing group Since active physical treatment is not offered by these centers this service to acutely disturbed patients must be approached cautiously

2 *Day hospitals*—This type of unit attached to a mental hospital would serve primarily early treatment patients with good prognosis although it would also be used to receive patients from the mental hospital who were not quite suitable for the day center or outpatient care Active treatment would be offered and for this reason close attachment to a bedded hospital is essential This arrangement also enables

A How Much Mental Illness?

Apart from the statistics furnished by mental hospitals, it cannot be said that we have any extensive knowledge of the actual incidence and prevalence of mental illness for any sizable region of the United States Hospitalization rates are available, and these show the tremendous variation among the states in the amount of hospitalization provided for the mentally ill (Council of State Governments, 1955) In forty one states reporting in 1953, mental hospitalization rates ranged between 1 5 patients per 1000 total state population (Tennessee) to 6 36 per 1000 (New York) Over a quarter of these states had rates in excess of 5 0 per 1000, and almost another quarter had rates below 3 0, the modal interval being 3 00 and 3 99, with fourteen states falling in this category Thus hospitalization rates in the United States tend to be somewhat above the western European countries reported on earlier in this chapter

THE AGED IN MENTAL HOSPITALS

In the United States, as in Europe, the aged constitute a major proportion of the mental hospital population In 1950, 25 per cent of all United States mental hospital patients were over 65 years of age, although only 8 1 per cent of the total population was over this age (Council of State Governments 1955) Here, again, marked differences between states appear, as is apparent from Figure 9. Thus Louisiana and North Carolina, with only 15 per cent of their patient population older than age 65, may be contrasted with thirteen other states in which these proportions are two or more times as great.

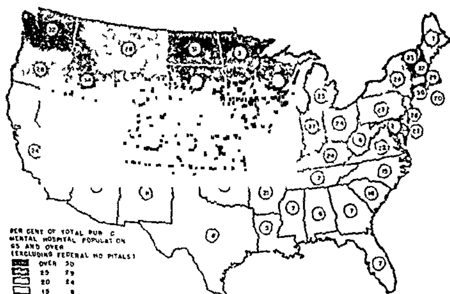


Fig 9—Percentage of total public mental ho pital population aged 65 and over in the United States in 1950 (From Council of State Governments *The States and Their Older Citizens* [Chicago The Council, 1955] p 76)

Interstate differences are even greater if we consider only first admissions to mental hospitals In 1950 Colorado had 46 9 per cent of its first admissions to state and county mental hospitals over age 65, followed by Iowa with 33 7 per cent and New York with 33 4 per cent. These three states were the highest in this respect, at the other end of the scales were North Caro

hospital would enable it to offer a full 24 hour service At this point the question of limits of service and perhaps a redefinition of function enter the picture, but experimentation is not yet complete in this country, and change is to be expected in the various methods of taking care of patients outside the mental hospital

5 *Aftercare* —According to the National Health Services Act, the aftercare of discharged mental patients is made the responsibility of the local authority This function, however, has not been well developed or organized Even in London where the most extensive work has been carried out, it is estimated that no more than 5 or 10 per cent of the discharged mental patients are followed by this service (Bickford, 1956)

6 *Hostels and social clubs* —As described elsewhere in this book, Great Britain has a well developed system of clubs for pensioners and for old people The problem of loneliness, not only for the aged, but for all age groups, is discussed and publicized in the press and on radio and television The National Old People's Welfare Council and the National Association for Mental Health have studied its implications and have directed a portion of their programs toward its mitigation It remains a problem

The Ministry of Health believes that loneliness is associated in an important, if not in a fully understood, way with mental illness, and the Ministry is, therefore, interested in any steps taken to combat this condition Particularly, it feels the need for hostels and social clubs for discharged patients but offers no extended program as yet whereby this end may be achieved on a broad national basis

II Expectations

British attitudes toward mental health are in flux, and traditional methods of dealing with the problem of mental illness are subject to criticism In this climate widespread change is inevitable Dr Donald McI Johnson, Member of Parliament for Carlisle, writes in the press that the improper admission of patients is one of the greatest problems confronting mental hospitals in Britain today (Johnson 1958) Though always legally correct, he charges that in too many cases the basis for hospitalization is medically and psychiatrically unsound He supports his argument by referring to the Amsterdam system which has been discussed earlier in this chapter and to the Worthing experiment, in which the effectiveness of intensive outpatient services in the reduction of hospital admissions is demonstrated (Carse *et al* 1958) General adoption of similar services throughout Britain he believes, would save upward of $28 million (£10 000 000) annually and produce therapeutic results vastly superior to those presently obtained Unquestionably, much can be learned by observing the steps taken in Great Britain during this period of critical self examination and change

VII United States

In the United States the major responsibility for the care of the mentally ill lies with the individual states Therefore, in spite of great national population the mental health problems faced by each state are more nearly comparable in magnitude to those of the smaller European countries than is at first apparent And for this reason too, the pertinency of European experience to American mental health problems should not be underestimated

Because several surveys covering much of the available information on the mental health of the aged in the United States are still current, it is unnecessary to go into great detail in this section (Council of State Governments 1955, Tompkins 1955 National Committee against Mental Illness, 1957), however, a brief overview of the American situation will be helpful for purposes of comparison with the European countries already touched upon in this chapter

COSTS

New construction and the remodeling of state hospitals are still major items of expense In November, 1955, a survey of state governments revealed that a total of $750 million had been appropriated for new construction, additions, and renovations to mental hospitals (National Committee against Mental Illness, 1957) By June 30, 1956 96 mental hospitals had been erected with the assistance of the federal government through the provisions of the Hill-Burton Act at a construction cost of $86,310,458 (National Committee against Mental Illness, 1957) These great amounts of money can hardly be deemed to represent a niggardly attitude on the part of responsible authorities, yet the expenditures are generally considered inadequate for immediate and long range needs

One index of the adequacy of patient care is the per capita cost In 1956 the maintenance expenditure in public mental hospitals in the United States was, on an annual basis, only $1,190.32 per patient, or about $3 26 per day These ranged from a high of $2,012 23 for the District of Columbia to $670 74 or about $1 84 per day, for Tennessee (National Committee against Mental Illness, 1957) These costs may be compared with Bickford's (1954) estimate of $2 00 for the daily per capita expend[illegible]

but [illegible]

the [illegible]

form these indexes into meaningful estimates of standards of care In both countries there is agreement that this amount is insufficient for the needs of modern therapy

STAFF

What constitutes an adequate hospital staff depends upon both qualitative and quantitative considerations, with the latter, being the more objective, the easier to specify The American Psychiatric Association (APA) has done this in establishing its standards of care (Table 29) These standards, however, must not be confused with actuality, in 1951, for example, only ten state mental hospitals in the entire country met the APA standard ratio for physicians, and in this same year these hospitals averaged only one psychologist to every 1,241 patients (Council of State Governments, 1953). In 1955, state hospitals had an average of only one physician to every 201 patients and one graduate nurse to every 82 patients (National Committee against Mental Illness, 1957) Thus it is apparent that

TABLE 29*

NUMBER OF PATIENTS FOR EACH OF SEVERAL TYPES OF PERSONNEL AS RECOMMENDED BY THE APA

Type of Personnel	Admission and Intensive Treatment Services	Continued Treatment Services	Geriatric Services
Physician	30†	150	150
Clinical psychologist	100	500	
Registered nurse	5	40	20
Occupational therapist	100	500	250
Attendant (all types)	4	6	4

* Source National Comm [illegible]

[illegible]

shortages in trained personnel exist and that these must be corrected before mental hospitals can perform their function in a completely satisfactory way

C Is the Psychiatric Hospital the Proper Place for the Aged Mental Patient?

If he is clearly ill mentally, unmanageable, and likely to remain so for an extended period, the answer to the question posed on the above heading is undoubtedly "Yes" On the other hand, as we have seen earlier in this chapter, there is a tendency for the helpless, ill, older person to be placed in the mental hospital because there seems to be no other place ready to take

lina with 12.5 per cent, Alabama with 11.9 per cent, and finally, Louisiana, with only 10.9 per cent of its first admissions above age 65 (Council of State Governments 1955).

Unquestionably, the highest first-admission rates are for patients above the age of 65, and this may be attributed entirely to the steep rise in the incidence rates for psychoses of the senium (senile psychoses and psychosis with cerebral arteriosclerosis). These rates begin to accelerate at age 40, rise sharply at 50, and zoom upward at 60. In the latter age group a first admission rate of 2.0 per 1000 population is reached—higher by far than the maximum reached by any other mental disorder for which hospitalization is sought (Collins 1955). Of interest is the fact that all other major categories of mental illness show declining incidence in the later years of life.

Yet in spite of the high proportion of the aged under treatment in mental hospitals and the very high admission rates for senile psychotics, it is wrong to conclude that hospital overcrowding may primarily be attributed to this type of patient. Actually, as might have been anticipated from the Danish hospital statistics given in Table 12, and from the high death rates for aged new admissions discussed elsewhere in the chapter, the number of beds occupied by senile psychotic patients is surprisingly low. Thus while 22.9 per cent of patients in Pennsylvania state hospitals were above age 65, only 7.7 per cent were senile psychotics, and in New York with 33.4 per cent of admissions above 65 only 12 per cent of the mental patients were senile or arteriosclerotic psychotics. It is apparent from these figures that a substantial number of the aged mental patients are those hospitalized during the earlier years of life and who remain there until the end of their days. Nevertheless the number of old people in mental hospitals is great: in 1950 a total of 141,346 patients were 65 or more years of age. This is just over 1 per cent of the total population in this age group (U.S. Congress 1957b), and as pointed out earlier it is approximately one-quarter of the total number of mental hospital patients.

B. How Adequate Are Facilities?

OVERCROWDING

Perhaps the most frequently voiced problem of mental health in the United States today is the overcrowding of mental hospitals. The years following World War II saw a phenomenal growth in the population of mental institutions. Overcrowded to begin with, the situation in state hospitals, which care for over 87 per cent of all mental patients in the nation (U.S. Congress 1957a), became very pressing indeed. This situation stimulated the building of some new hospitals and increases in the capacity of others, but perhaps of greater importance is the fact that the states were forced to conclude that custodial hospitalization would never provide a solution to the costly problem of mental illness. It was recognized that, in order to cut down the length of stay of mental patients in hospital and to lower the new admission rate, more and better trained personnel would be necessary and new ways of treating mental illness would have to be discovered. This encouraged the state governments to assume increasing responsibility for training and research in mental health (Council of State Governments 1953; Kleemeier, 1956b).

However, training and research programs are still behind the need, and overcrowding is still the rule. By the mid 1950's the National Association for Mental Health reported that mental hospitals had only about 56 per cent of the number of beds needed to give good patient care (National Committee against Mental Illness 1957). When one considers that in 1955 the average daily hospital census of patients was 740,295 and that there are about 600 mental hospitals in the United States, the almost staggering dimensions of this problem become apparent (National Committee against Mental Illness 1957).

when other alternatives cannot be found Although this type of patient is found in large numbers in state hospitals, this number is not sufficiently large to account for all existing overcrowding

D What Is Being Done To Improve Care of the Mentally Ill Aged?

In the above sections some of the steps taken by the states have already been mentioned No clear pattern seems to have emerged as yet from the welter of policy changes legislative acts and various building and other programs that have developed through the past decade Many of the states are however, taking responsible action Thus funds have been made available by the state of Connecticut to assist private non-profit hospitals to improve their standards of care and for the development of home-care programs protective workshops foster home programs etc., in local communities

Following the experience and example of Dr Querido in Amsterdam Dr Maurice E Linden director of Philadelphia s mental health division has begun in that city a program of psychiatric and social work counseling aimed at maintaining in the home patients who might otherwise be institutionalized Earlier while at Norristown State Hospital, Dr Linden (1956) found that a variety of medications used in conjunction with an active program of group therapy brought therapeutic benefits to a wide age range of patients, including the elderly

EFFECTS OF TREATMENT ON HOSPITAL POPULATION

In the United States, as in England an arresting of the post World War II upward trend in mental hospitalization is beginning to be experienced Again increases in rate of discharge rather than decreasing admissions seem responsible Between April 1955 and April, 1956 New York State found a 23 per cent increase in discharges from its mental hospitals New York s mental health commissioner writes "For the past 10 years, our hospitals have been growing by about 2 000 patients each year On March 31, 1956, however, there were 500 fewer patients in state hospitals than on March 31, 1955 ' (National Committee against Mental Illness, 1957)

Similar experiences were reported in 1956 by a total of thirty four states and the District of Columbia. Nationally, for the first time in history, state mental hospitals showed a decline in population The reduction of about 7000 patients, while seemingly small, must be viewed in the perspective of an average increase of 10,000 patients every year since 1945 (National Committee against Mental Illness, 1957)

This improvement cannot be attributed to any single factor, but certainly the tendency for state legislatures to provide more money so that more intensive treatment is possible and that more medical personnel is available stands high in any listing of responsible agents Thus in 1956 the ratio of full time state hospital employees to patients was 3 6, this was just about double the 1945 ratio of 6.8 patients for every employee The 1956 daily expenditure figure of $3 26 per patient was more than three times that of 1945 Between 1945 and 1955 great increases were effected in the number of medical and other professional personnel in the state hospitals, which, along with widespread use of tran- [illegible] of the fact that early in the 1950 s only 40 per cent of state mental hospital patients were discharged within 5 years of admission (National Committee against Mental Illness, 1957)

While undoubtedly better facilities and care have improved the lot of the aged mental patient, the reduction in hospital population has not come from this group For example, the rate for cerebral arteriosclerotic patients falls well below the average for all mental patients In 1952 only

him Concern has been expressed in England and Denmark about the number of aged admitted to mental hospitals who might be more appropriately placed in another setting In France and Italy the number of aged new admissions has been reduced simply by excluding cases whose condition would not warrant mental hospitalization The same problem has been met in the United States, and various approaches to it have been adopted Dorothy C Tompkins (1955), in the opening paragraph of a study of the senile aged in the United States, says

> There are thousands of aged persons in mental hospitals because there is no other place for them They are called senile, unadjusted, elderly, or emotionally labile They overburden the facilities for care of the mentally ill and their special treatment needs cannot be met in this kind of environment

The protest has been made that the commitment of the aged, mentally frail person is the expression of a growing sociologic trend reflecting the inability of the family to care for the chronically helpless person in the home However, even if we accept as a premise the inability of the modern home to carry the burden imposed by a senile family member, it still does not follow that the mental hospital is the necessary institution to provide the essential care In Connecticut, for example, a broad program of rehabilitation for the "unadjusted elderly" has been instituted in order to relieve overcrowded conditions in mental hospitals (Tompkins, 1955)

Other states have adopted the same hard minded attitude of France and Italy and closed their doors to the non psychotic aged California announced a policy of discharging from state hospitals patients "merely affected with harmless chronic mental unsoundness" to responsible relatives or to the proper local county authorities The application of this standard to admissions in 1954 resulted in 500 fewer new mental patients over the age of 65 than in 1953 (Tompkins, 1955) Two other states, Maine and Missouri, have also adopted laws designed to avoid admissions of aged patients who do not need the psychiatric care of mental hospitals (Council of State Governments, 1955)

Minnesota's experience with the "senile problem" is particularly interesting Various well publicized improvements in facilities and care of aged mental patients resulted in an overloading of the state hospitals with between 600 and 700 patients who could be more properly cared for in facilities other than a mental institution In an attempt to correct this condition, the state initiated efforts designed to make the local communities and the patients' families assume more responsibility for their care To this end recommendations were made for legislation to enable the state to charge relatives or, in the event of their inability to pay, the local communities from which they came Local communities were also encouraged to build appropriate nursing homes or other similar institutions to provide for the needs of the mentally frail, dependent person (Tompkins, 1955)

Progress is reported from the largest state, New York but here, too problems abound

> An experimental geriatric building was authorized by the 1953 legislature, segregation in the State mental hospitals in separate geriatric or infirmary services is now close to achievement, and the research unit of one State hospital is being reorganized to devote its entire attention to arteriosclerotic and senile changes
>
> The realities of the situation in New York State are suggested by the fact that Supreme Court Justice Benjamin Brenner disclosed recently (1954) that he had reluctantly' certified four elderly sane persons as mentally ill to get them the custodial care they needed [Tompkins 1955]

More documentation could be added to support the simple conclusion that there exists nationally in the United States a shortage of facilities to provide care for the mentally frail and helpless aged person at a cost which he and/or his responsible relatives can afford This has led the state mental hospitals reluctantly to fill this need

when other alternatives cannot be found Although this type of patient is found in large numbers in state hospitals this number is not sufficiently large to account for all existing overcrowding

D What Is Being Done To Improve Care of the Mentally Ill Aged?

In the above sections some of the steps taken by the states have already been mentioned No clear pattern seems to have emerged as yet from the welter of policy changes legislative acts and various building and other programs that have developed through the past decade Many of the states are however, taking responsible action Thus funds have been made available by the state of Connecticut to assist private non profit hospitals to improve their standards of care and for the development of home-care programs protective workshops foster home programs etc. in local communities

Following the experience and example of Dr Querido in Amsterdam Dr Maurice E Linden director of Philadelphia s mental health division has begun in that city a program of psychiatric and social work counseling aimed at maintaining in the home patients who might otherwise be institutionalized Earlier while at Norristown State Hospital Dr Linden (1956) found that a variety of medications used in conjunction with an active program of group therapy brought therapeutic benefits to a wide age range of patients including the elderly

EFFECTS OF TREATMENT ON HOSPITAL POPULATION

In the United States as in England an arresting of the post World War II upward trend in mental hospitalization is beginning to be experienced Again increases in rate of discharge rather than decreasing admissions seem responsible Between April 1955 and April 1956 New York State found a 23 per cent increase in discharges from its mental hospitals New York s mental health commissioner writes "For the past 10 years our hospitals have been growing by about 2 000 patients each year On March 31, 1956, however, there were 500 fewer patients in state hospitals than on March 31, 1955 ' (National Committee against Mental Illness 1957)

Similar experiences were reported in 1956 by a total of thirty four states and the District of Columbia. Nationally, for the first time in history, state mental hospitals showed a decline in population. The reduction of about 7000 patients, while seemingly small must be viewed in the perspective of an average increase of 10 000 patients every year since 1945 (National Committee against Mental Illness, 1957)

This improvement cannot be attributed to any single factor, but certainly the tendency for state legislatures to provide more money so that more intensive treatment is possible and that more medical personnel is available stands high in any listing of responsible agents Thus in 1956 the ratio of full time state hospital employees to patients was 3 6, this was just about double the 1945 ratio of 6 8 patients for every employee The 1956 daily expenditure figure of $3 26 per patient was more than three times that of 1945 Between 1945 and 1955 great increases were effected in the number of medical and other professional personnel in the state hospitals, which along with widespread use of tranquilizing drugs enabled a number of top ranking state mental hospitals to discharge from 65 to 80 per cent of their first admissions This is a remarkable achievement in view of the fact that early in the 1930 s only 40 per cent of state mental hospital patients were discharged within 5 years of admission (National Committee against Mental Illness, 1957)

While undoubtedly better facilities and care have improved the lot of the aged mental patient, the reduction in hospital population has not come from this group For example the rate for cerebral arteriosclerotic patients falls well below the average for all mental patients In 1952 only

18 per cent of such patients were discharged within 5 years of admission, and 70 per cent died within this period (National Committee against Mental Illness, 1957). Wholly satisfactory solutions to the problems presented by the aged mental hospital patient are yet to be found.

TRENDS AND DEVELOPMENTS

Recommendations directed at improving the mental health of the aged fall into four major classes: (1) improvement of traditional facilities plus the development of newer types to provide better care for the dependent aged; (2) better provision for various kinds of supportive and rehabilitative services; (3) more and better trained personnel to deal with social and medical needs of aged; and (4) research into social, psychological, and medical aspects of aging (Council of State Governments, 1953, 1955; Kleemeier, 1956*a;* Linden, 1956; National Committee against Mental Illness, 1957; U.S. Congress, 1957*a*, 1957*b*, 1957*c*). Thus the report of the Council of State Governments suggests the development of a number of different kinds of facilities as alternatives to mental hospitals for the aged (Council of State Governments, 1955). These include day care centers, manifold home-care services, foster and boarding homes, old age and nursing homes, "halfway houses," and geriatric centers.

It is not simply that a shortage of these facilities and services exists, but of equal or greater importance is the general lack of awareness that such services and institutional settings can be fashioned into an effective apparatus for the alleviation of mental and physical distress of the aged The latter is largely a matter of education, training, and effective applied research Fortunately, steps have been taken in this direction which should not only provide trained experts with special interests and skills in gerontology but also, by providing courses in colleges and universities, help create a body of gerontologically informed laymen who can be counted upon to support efforts to improve the situation of the aged in society.

The United States has much to learn about the care and treatment of its mentally frail aged, but it has much to teach also. The current picture is sometimes depressing, but progress is being made and should continue at an accelerating pace Certainly, the research efforts under way should point to bright future development, but with a steadily mounting population of aged people there is no time for complacency.

REFERENCES

BICKFORD, J A. R 1954 Treatment of the chronic mental patient *Lancet*, 1, 924–27

——. 1956. Certifying the old *Ibid*, 271, 1105–6

BOUCHER, C A 1957 Survey of services available to the chronic sick and elderly in 1954–1955. ("Ministry of Health Reports on Public Health and Medical Subjects," No 98) London H M Stationery Office

CA[illegible] J, [illegible], N F and WATT, A 1958 [illegible] Worth- [illegible]

CL[illegible] mental hospital Lancet, 271, 1005–9

COLLINS, S D 1955 A review of illness from chronic disease and its variation with age, sex, and season, with some trends J Chronic Dis, 1, 412–41

CONFERENCE OF THE MINISTERS OF SOCIAL AFFAIRS OF THE NORTHERN COUNTRIES 1957 Samordnad nordisk statistik rörande social lagstiftningen ("Co-ordinated statistics of social welfare in the northern countries") ("Nordisk Statistisk Skriftserie," No 4) Stockholm The Conference

COOK, L C, DAX, E C, and MACLAY, W S 1952 The geriatric problem in mental hospitals Lancet, 1, 377–82

COSIN, L 1954 The place of the day hospital in a geriatric unit Practitioner, 172, 552–59

COUNCIL OF STATE GOVERNMENTS 1953 Training and research in state mental health programs Chicago The Council

——. 1955 The states and their older citizens Chicago The Council

DENMARK MINISTRY OF INTERNAL AFFAIRS 1956 Betænkning afgivet af kommissionen af 29 marts 1952 vedrørende Statens sinds-

sygevæsen (Betænkning No 165) Copenhagen Statens Trykningskontor
DENMARK. MINISTRY OF LABOR AND SOCIAL AFFAIRS 1957a Alderdomshjemmene og deres beboere (Arbejds og Socialministeriernes Økonomisk Statistiske Undersøgelser No 23) Copenhagen
—
FRANCE. MINISTRY OF HEALTH 1953 Plan
— 1958 Deuxième plan d équipment 1958-61 hôpitaux psychiatriques Parts I IV Paris Ministry of Health (Mimeographed.)
FRIIS H 1955 Personer under Ødsbsternes Åndssvageanstalts forsorg (Arbejdsog socialministeriernes Økonomisk Statistiske Undersøgelser No 20) Copenhagen
GREAT BRITAIN MINISTRY OF HEALTH 1955 Report for the year ended 31 December 1954 Part I London H M Stationery Office
—— 1956 Report for the year ended 31 December 1955 Part II London H M Stationery Office
—— 1957a Report for the year ended 31 December 1956 Part I London H M Stationery Office
—— 1957b Report for the year ended 31 December 1956 Part II London H M Stationery Office
GREAT BRITAIN ROYAL COMMISSION ON THE LAW RELATING TO MENTAL ILLNESS AND MENTAL DEFICIENCY 1957 Report 1954-1957 London H M Stationery Office
GUTTERSEN A G 1956 Ideas underlying Danish hospital planning Ment Hospitals 7 21
HAGNELL O 1954 Psykoser hos äldre manniskor ett växande psykiatriskt problem (Psychosis in the aged an increasing psychiatric problem) Nord med 51 737-42
JOHNSON D McI 1958 New deal lies ahead for mentally sick Bristol Evening Post February 5 p 2
JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH 1956 First annual report Cambridge Mass The Commission (Mimeographed.)
KLEEMEIER R W 1956a An analysis of patterns for group living for older people In I L. WEBBER (ed), Aging a current appraisal pp 167 79 Gainesville University of Florida Press
—— 1956b A program for mental health training and research in Florida the annual report of the Florida Council on Training and Research in Mental Health Jacksonville Florida State Board of Health (Mimeographed)
—— 1956c Training needs in psychosocial gerontology and the problems of mental health in the elderly Orange Park, Fla Moosehaven Research Laboratory (Mimeographed)
—— 1957a Criteri per la misurazione della salute mentale Longevità (Milan) November December pp 190-98
—— 1957b Criteria for measuring social mental health of an aging population G ior gerontol 5 1097 1102
—— 1958 Somatopsychologic effects of illness in the aged person Geriatrics 13, 441 49
LARSSON T and SJOGREN T 1954 A method olog cal re h
LE [illegible] plans for psychiatric institutions in Denmark Ment Hospitals 7 22 27
LINDEN M E 1956 Public policy and mental problems of the aging In NEW YORK STATE JOINT LEGISLATIVE COMMITTEE ON PROBLEMS OF THE AGING New channels for the golden years pp 77-80 (Legislative Doc No 33) Albany N Y The Committee
NATIONAL COMMITTEE AGAINST MENTAL ILLNESS 1957 What are the facts about mental illness in the United States? Washington D C The Committee.
NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE 1955 Technical report of the Mental Health Research Unit Ithaca N Y Syracuse University Press
NYBLAEUS I 1956 The mental health film service of the Swedish Association for Mental Health World Ment Health 8, 35-36
QUERIDO A 1948 Early diagnosis and treatment services In The elements of a com
—— 1948-49 Experiment in mental health Social Service 22 125-30 169 71

18 per cent of such patients were discharged within 5 years of admission, and 70 per cent died within this period (National Committee against Mental Illness, 1957). Wholly satisfactory solutions to the problems presented by the aged mental hospital patient are yet to be found

TRENDS AND DEVELOPMENTS

Recommendations directed at improving the mental health of the aged fall into four major classes: (1) improvement of traditional facilities plus the development of newer types to provide better care for the dependent aged; (2) better provision for various kinds of supportive and rehabilitative services; (3) more and better trained personnel to deal with social and medical needs of aged; and (4) research into social, psychological, and medical aspects of aging (Council of State Governments, 1953, 1955; Kleemeier, 1956a; Linden 1956; National Committee against Mental Illness, 1957; U.S Congress, 1957a, 1957b, 1957c). Thus the report of the Council of State Governments suggests the development of a number of different kinds of facilities as alternatives to mental hospitals for the aged (Council of State Governments, 1955) These include day care centers, manifold home-care services, foster and boarding homes, old age and nursing homes, "halfway houses," and geriatric centers

It is not simply that a shortage of these facilities and services exists, but of equal or greater importance is the general lack of awareness that such services and institutional settings can be fashioned into an effective apparatus for the alleviation of mental and physical distress of the aged The latter is largely a matter of education training, and effective applied research Fortunately, steps have been taken in this direction which should not only provide trained experts with special interests and skills in gerontology but also, by providing courses in colleges and universities, help create a body of gerontologically informed laymen who can be counted upon to support efforts to improve the situation of the aged in society.

The United States has much to learn about the care and treatment of its mentally frail aged, but it has much to teach also. The current picture is sometimes depressing, but progress is being made and should continue at an accelerating pace Certainly, the research efforts under way should point to bright future development, but with a steadily mounting population of aged people there is no time for complacency.

REFERENCES

BICKFORD, J A R 1954 Treatment of the chronic mental patient Lancet, 1, 924-27

——— 1956 Certifying the old Ibid., 271, 1105-6

BOUCHER, C A 1957 Survey of services available to the chronic sick and elderly in 1954-1955 ("Ministry of Health Reports on Public Health and Medical Subjects," No 98)

CA [illegible] 1958 [illegible] rth [illegible] ing experiment Lancet, 1, 39-41

CLARK, D H 1956 Functions of the mental hospital Lancet, 271, 1005-9

COLLINS, S D 1955 A review of illness from chronic disease and its variation with age, sex, and season, with some trends J Chronic Dis, 1, 412-41

CONFERENCE OF THE MINISTERS OF SOCIAL AFFAIRS OF THE NORTHERN COUNTRIES 1957 Samordnad nordisk statistik rorande socialvagstiftningen ("Co-ordinated statistics of social welfare in the northern countries") ("Nordisk Statistisk Skriftserie," No 4) Stockholm The Conference

COOK, L C, DAX, E C, and MACLAY, W S 1952 The geriatric problem in mental hospitals Lancet, 1, 377-82

COSIN, L 1954 The place of the day hospital in a geriatric unit Practitioner, 172, 552-59

COUNCIL OF STATE GOVERNMENTS 1953 Training and research in state mental health programs Chicago The Council

——— 1955 The states and their older citizens Chicago The Council

DENMARK MINISTRY OF INTERNAL AFFAIRS 1956 Betænkning afgivet af kommissionen [illegible]

VIII

Family Structure and Relationships[1]

ERNEST W BURGESS

I The Future of the Extended Family

Older people before the industrial revolution experienced their main satisfactions in life through their membership in the extended family They found in it security response and recognition In their role of advice giving and assistance to their adult children they performed a vital function

A Economic and Social Trends

But the effects of economic and social trends in the last 100 years has been to decrease the economic function of the extended family and at the same time to change the role and status of older persons Several of these trends described in chapter 1 which particularly affected the aging in their family relationships will be briefly recapitulated

1 *The change from home to factory production* meant the sharp separation of work and the family which had previously been united Both the large and the small family groups lost their function as units of economic productivity Older as well as younger persons were now usually employees rather than employers Women also left the home to work in factories and in offices

2 *The development of the urban way of life* supplanted the earlier rural patterns of behavior The country had been a favorable environment for the older person and for the extended family which he headed The city, with its smaller home

[illegible]

[illegible] conditions for the independence of the nuclear from the extended family

3 *The rise of large organizations* in society provided a substitute for the extended family The security in employment and retirement which the person had previously enjoyed in the extended family, he now found increasingly in large organizations—economic, social, cultural and political The company and the labor union

[1] Grateful acknowledgment is given to those who

[illegible] Public Assistance Department Milan Italy Siegfried Gebauer Bundesministerium fur Familienfragen Bonn Germany Maria Hage-

[illegible]

[illegible] Italy A Kaan, Amsterdam, The Netherlands Lars Ögren Swedish Institute of Public Opinion Research Angelo Pagani Institute of Public Assistance Milan, Italy Max Rheinstein Law School University of Chicago Chicago Helmut Schelsky Hamburg University Hamburg Germany Rudolf Tartler Hamburg University Hamburg Germany Peter Townsend Department of Social Science London School of Economics and Political Science London England Jean René Tréanton Centre National de la Recherche Scientifique Paris, France Elmo C Wilson, International Research Associates, Inc., New York Robert J van Zonneveld, National Health Research Council T.N.O The Hague Netherlands Angela Zucconi School of Social Work Rome Italy

SJÖGREN H 1954 Neuropsykiatriska sjukdomar i presenium och senium Nord med , 52, 1083–91

STERN, E S 1957 Operation sesame Lancet, 272, 577–78

STRÖMGREN, E 1958 Mental health service planning in Denmark Danish Med Bull , 5, 1–17

SWEDEN CENTRAL BUREAU OF STATISTICS 1956 Statistisk Årsbok for Sverige ("Statistical abstract of Sweden"), Vol 43 Stockholm The Bureau

SWEDEN ROYAL MEDICAL BOARD 1957 Allmän Halso och Sjukvård, 1955 ("Public health and sick care in Sweden annual report of the Royal Medical Board, 1955") ("Sveriges Officiella Statistik") Stockholm Kungl Medicinalstyrelsen

TOMPKINS, DOROTHY C 1955 The senile aged problem in the United States ("1955 Legislative Problems," No 1) Berkeley Bureau of Public Administration, University of California

U S CONGRESS SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE 1957*a* Studies of the aged and aging, Vol 2 Health and health services Washington, D C Government Printing Office

——— 1957*b* Studies of the aged and aging, Vol 9· Research demonstration and training Washington, D C Government Printing Office

——— 1957*c* Studies of the aged and aging, Vol 11· Fact book on aging Washington, D C Government Printing Office

WORLD HEALTH ORGANIZATION 1953 The community mental hospital ("Technical Report Series," No 73) Geneva World Health Organization

——— 1957*a* Annual epidemiological and vital statistics, 1954 Geneva World Health Organization

——— 1957*b* Fifth WHO expert committee on mental health. World Ment Health, 9, 20–21

of patriarch in ordering the destiny of his children and grandchildren He cannot even be sure of being venerated and respected In short he has lost his old role of dominance and has not yet found a new one [pp 50–51]

Kooy (1957) a sociologist engaged in a study of changes in the Dutch nuclear family, states

> Hofstee shows that the bonds between nuclear and extended family weakened which implied that the extended family as a living unit shriveled This individualization [of the nuclear family] has not yet reached the same phase everywhere in Holland In bourgeois circles it began early already before the French Revolution Among the laborers and the agrarian population we find the first signs of it much later but among the agrarian population in the coastal provinces [the northern and wes ...]
>
> trend everywhere in all regions and in all circles the nuclear family becomes a more autonomous unit in its relations with the extended family and the local group

Baumert (1957) asserts that changes in family structure are producing new relationships between the generations

> The situation of old people has been strongly affected by social and economic changes in recent times Changes in family structure and living not only affect the status of aging parents but brings about new relationships between the generations the young who would be modern and the old who have lived their lives in relation to older family patterns
>
> The problems involved not only concern the aging parents but concern in different ways their children and the families of their children]
>
> archal
>
> of the

The separation of the generations has become a generally accepted pattern said Myrdal and Klein (1956) in their study of women in Western countries

There has been some controversy, particularly in England as to factual evidence on the present status of the extended family This has led at least in part to the making of several intensive studies on the nature of family structure in its relation to the kin and the neighborhood One of these, by Peter Townsend on *The Family Life of Old People,* is specifically devoted to the family relationships of aging persons in Bethnal Green a working-class district of East London A second investigation by Young and Willmott on *Family and Kinship in East London,* reports on family relations of the middle aged both in Bethnal Green and upon migrants to a suburban housing estate A third study, by John M Mogey on *The Family and the Neighbourhood* deals with the effect on family relations of the move from a working-class to a residential neighborhood A fourth project by Elizabeth Bott on *The Family and Social Network,* analyzes in great detail twenty families of different occupational levels both in their conjugal roles and in their familial and social networks of contacts

All these writers emphasize the persistence of the extended family among the English working class as a unit of social relations and mutual aid As will be seen later Young and Willmott (1957) and Mogey (1956) note the change in the frequency and nature of social contacts as the nuclear family moves from the working class district to a new residential suburb No other country of Western culture has such a wealth of available material on family structure and relationships as they affect older members and these sources will be drawn on heavily in our survey of the changes in the family relationships of aging people

B Adaptability of Family Structure

Family structure has always shown great flexibility in its adaptation to different economic and social conditions Among preliterate and historical peoples it has exhibited a high degree of variability It has taken different forms according to number and sex of spouses as monogamous polygamous polyandrous and group marriage The extended family has been organized in

gave him security in his job The government organized and administered unemployment insurance workmen's compensation, permanent disability insurance, Old Age and Survivors Insurance, and old age assistance For his activities and social life the older person could now turn to radio television and motion pictures conducted by large commercial organizations to parks and museums operated by public or private agencies or to clubs under the auspices generally of private but increasingly of public organizations

4 *Automation and the increase of leisure time* were manifested only in part by the institution of voluntary and compulsory retirement Retirement raised the question of how older people were to plan and prepare for the new leisure It provided the conditions for a new career for older people largely independent of their children and grandchildren

5 *The conservation of human life* had resulted in spectacular decreases in diseases of infants and small children and marked declines in communicable diseases of early and middle adulthood As a consequence the proportion of people living beyond 65 had doubled since 1850 in European countries of Western culture The care of the aged as well as all sick persons had been in the home by members of the immediate and extended family but now the older ill person was treated in the clinic the hospital the nursing home or other community facility

What have been the effects of these changes upon the structure of the extended family and the relations of its members? Will it survive or perish? If it survives what form will it take? Students of old age and the family in different countries of Western culture point out the changes affecting the extended family

Sauvy (1955) emphasizes the role of the geographical dispersion of the family or at least of the family in the wide sense of the word

> The increase of communication and the growth of urbanization separated the generations The young family frequently lived in the town while the old father was left in the country Later the town family now grown old found itself in turn separated from the children at least from the point of view of housing
>
> Professional dispersion was added to geographic dispersion The family ceased to work as a family the man went off to work in one factory the wife in another—and solidarity suffered
>
> The geographic dispersion of the family was accompanied by a *decrease in parental authority* This decrease which was part of the general pattern of enfranchisement was accompanied by an emancipation of the wife and children [p 29]

Sir Geoffrey King (1955) points to the change from the agricultural to the modern industrial community

> In an agricultural or peasant community old people tend to remain until the end as useful members of a family group carrying out such tasks as their strength and circumstances permit in return for which they are looked after and provided with board and lodging Modern ideas have disrupted this way of life No one in these days would dare publicly to advise young married couples to live with their parents In the old days sons and daughters used to take jobs or marry in the neighbourhood of the family home Nowadays *mobility* of labour is the cry and sons may have to go long distances in search of work These are no doubt the inevitable results of the modern industrial community [p 37]

Burgess (1955) has expressed the American point of view

> *In the rural neighbourhood* of the past social relationships were kinship centered Naturally where familism predominated the role of grandparents was clearly defined Their power was great and their status was high In the urban way of life family and kinship relations more and more take second place to associations with persons selected on the basis of occupational and avocational interests and similarity of ideas and values Family and kinship ties still persist but they are no longer central and vital The result is that the older person feels dethroned and devalued in the realm of family relations where he once reigned supreme He can no longer count on the role

social life independently of each other The usual forms of recreation for men are drinking and visiting friends in the local pub engaging in some sport, and attending public athletic matches

c) Women spend their free time visiting with their mother sisters and other relatives (Bott 1957) One local man sized up the difference between husbands and wives Men have friends women have relatives' He added Women don t have friends they have Mum

d) A system of mutual help in time of need is carried on by the grandmother, daughters sisters and granddaughters

e) In the small families within the extended family there is a strict separation of the conjugal roles of husband and wife The husband controls the money and does not tell the wife what he earns He gives her the housekeeping allowance customary n the ...

[illegible]

shared interests

The maternal extended family suffers defections when any married couple moves out of the neighborhood For example Bethnal Green has lost within recent years nearly half of its population by migration to suburban areas

3 *The autonomous nuclear family*— The nuclear or conjugal family is the predominant form in residential areas of the city Bott (1957) describes this type of family as having a joint conjugal role relationship associated with a loosely knit network ...

fo ...

th ...

h ... some distance from it (*b*) there is little sociability with neighbors the majority of friends of the residents living outside the area and frequently being widely scattered (*c*) few if any, relatives live in the same or adjoining neighborhood but are often widely dispersed over the city and (*d*) residential and social mobility is high couples when they marry tend to reside in other neighborhoods

Prominent characteristics of the autonomous nuclear family are (*a*) that equal authority is shared by husband and wife, (*b*) that the division of labor between husband and wife is flexible and roles are easily reversed, (*c*) that compatibility of personality and complementary differences are regarded as desirable by the couple for a happy marriage, (*d*) that nearly all friends are joint friends of husband and wife, (*e*) that there is a minimum of social control by friends and neighbors, and (*f*) that leisure-time activities are largely together, with emphasis upon entertaining and being entertained by friends

This rapid survey of the three types—large patriarchal extended family, maternal extended family, and nuclear or conjugal family—suggests certain generalizations

The patriarchal extended family has almost disappeared from countries of Western culture Survivals may still persist in isolated rural areas (see pp 277–81) It also sometimes develops where the owner of a family business employs his sons and perhaps sons in law and especially if also all the component nuclear families live near by or, as is sometimes the case, occupy apartments in the building belonging to the patriarch

The maternal extended family appears to be still well intrenched in homogeneous working-class neighborhoods where the residents are employed by local industry It is most stable where at least three or four generations have been born and reared in the same locality The departure of couples to residential suburbs loosens their membership in this type of extended family These mobile conjugal units tend to become autonomous and to take on the characteristics of the residents of the new residential neighborhood

The autonomous nuclear family has the characteristics which seem adapted to the urban way of life Husband and wife no longer seek their chief companionship outside the home—the husband with friends and the wife with relatives—as in the ma

different ways and has varied by patrilineal and matrilineal descent and by patrilocal and matrilocal residence Systems of land tenure, with their various provisions for the inheritance of property, have also shaped the structure of the family

For purposes of our survey of family structure and relationships in countries of Western culture our discussion will be limited to three types of the family (1) the patriarchal extended family on the farm and in the towns, (2) the maternal extended family in urban industrial neighborhoods, and (3) the autonomous nuclear family of urban residential districts

1 *The patriarchal extended family*—The extended family was once the prevalent form in all human societies It is universal among primitive peoples in two general types, the maternal and the paternal Among peoples of ancient civilization, and still today in oriental countries, it took the form of the large patriarchal family with authority and decision making in the hands of its head usually the oldest male member Le Play (1935) regarded the patriarchal form as the best representative of the family, since "it has a stable and permanent relationship with its fireside, it is faithful to traditions and it establishes its married children near the homestead in order to watch over them and to preserve them" (pp 98–99) Marriages of sons and daughters were arranged by parents for reasons of economic and social status rather than according to the personal inclinations of the young people

The patriarchal form of the extended family was an economic unit of production both in farming in the country and in carrying on trades in the town As skill and discipline became more important in agriculture and in the crafts, the large patriarchal form was replaced by the semipatriarchal type of the extended family In France this took the form of the "stem family," to use a term applied to it by Le Play (1935) It operated under a system of land tenure which guaranteed the inheritance of an estate, family name, and traditions from generation to generation. He applied this name to "the family which maintains a homestead for its immediate members and sends the other members elsewhere to make their own living"

When the father died, the oldest son inherited the family estate by the law of primogeniture The latter in France had the obligation to support his unmarried brothers and sisters on the ancestral farm It was his duty to help his sisters make advantageous marriages He also had a responsibility to his brothers for their professional education or for getting them placed as apprentices The homestead remained a haven to which his brothers and sisters might claim shelter (A critique of the point of view of Le Play has recently been made on the basis of research upon the evolution of the French rural family [see Lefebvre, 1953])

Le Play saw this stable form of family structure threatened by industrialization the growth of the cities, and the rise of individualism He advocated a social policy that would preserve the small patriarchal family as a stable unit of society

2 *The maternal extended family*—According to the studies by Mogey (1956) Townsend (1957), and Young and Willmott (1957) the maternal extended family exists in an urban neighborhood with three characteristics (*a*) it is a working class industrial district in which its inhabitants work and live (*b*) it is a *closed* neighborhood in the sense that practically all the social activities of the inhabitants are carried on within its boundaries, and (*c*) couples when they marry tend to settle close to their parents especially to those on the maternal side

The outstanding features of the maternal extended family are

a) The nucleus of the maternal extended family is constituted by the grandmother her daughters and granddaughters

b) Men visit relatives but less frequently than do the women Husbands and wives enjoy much of their recreation and

only one is giving support The worst situation for older people is to have no family and also to be in poor health

THE NETHERLANDS

The law requiring adult children to support needy parents is well enforced in the Netherlands. The legal provision that grandchildren be liable to the support of grandparents is in the process of being repealed and is no longer enforced Old age assistance officials state that there is some difficulty at times in getting children to contribute to the support of their needy parents But often when the situation is explained they will agree or even offer to make regular payments There is some public sentiment developing against requiring children to make contributions for the support of their parents (personal communication from Dr A. Kaan 1957)

WEST GERMANY

Each district in West Germany has a social office for matters like old age assistance The social worker investigates the need of the older person who applies for assistance and then goes to the next of kin to find out his ability and willingness to give support If the recommended payment is not made the matter is taken to court Parents are becoming more l...

su

m

... age assistance to rural areas under the Association of Farmers provides for benefits at 65 This means that older persons will no longer be dependent on their children for support and this should lead to an earlier transfer of the farm to the oldest son

Older people in rural areas are reported to be happy and relieved at the prospect of obtaining insurance benefits In the past there were frequent quarrels and disputes over the support money due the aged farmer who had given up the management of the farm Sometimes the question of amount of support depended on the attitude of the daughter in law, and this was a cause of anxiety to the old people

ENGLAND

The United Kingdom is the one nation of our six countries of Western culture which has abolished legislation requiring adult children and other relatives to support aging parents who are in need It has also the most highly developed program of medical and community services for the ...

people from relatives since it is freely given and not under legal compulsion

Where the extended family still flourishes, as in Bethnal Green Townsend (1957) reports that older persons and their families (whether living together or apart) engage in a system of reciprocal services In the Bethnal Green sample the aging obtained help not only in illnesses but when needed in shopping cleaning washing and cooking Regular help in these or other household tasks was received by 68 per cent of the aging and occasional help by 21 per cent Only 11 per cent received no help The old people reciprocated when able Townsend reports that, except for those living completely alone 91 per cent of women and 60 per cent of men did some daily or weekly service such as daily shopping preparation of meals looking after grandchildren or occasional service Only 13 per cent of the old women and 40 per cent of the old men undertook no regular personal or domestic help for others This family system of reciprocal care is centered in an old woman and participated in much more by her her daughters and daughters in law, and sisters and nieces than by male relatives

B Aging Parents Living with Adult Children

In all countries of Western culture a minority of aging parents still live with their adult children It is however impor

ternal extended family They find it with each other They select friends not from those who live in the same block but on the basis of common tastes interests and similar backgrounds who are likely to reside in other neighborhoods They are freed from the control of kin and neighbors

The autonomous nuclear family seems destined to be the family of the future It is still in the process of evolution Its central value is companionship of husband and wife and of parents and children It recognizes increasingly the sharing of authority by the spouses and their equality in status It is a product of the effects of the economic and social trends of the times

In this transition from the extended to the nuclear family what becomes of the relations of aging parents to their children? How have the relations of grandparents and grandchildren been affected? What changes take place in the relations of the aging husband and his wife? What are the family relations of those unattached to the nuclear family—the widowed the single and the divorced—who in the past could find refuge in the extended family? What changes of adjustment in family relations are taking place to conditions and trends of modern life?

Data bearing on the answers to these questions will now be presented

II Aging Parents and Their Adult Children and Grandchildren

The changes in the relations of aging parents and their adult children and grand children will be discussed under the following heads (*a*) support of parents by their children (*b*) aging parents living with adult children (*c*) parent child relations and (*d*) grandparent grandchildren relations

A Support of Parents by Their Children

In the past in all countries of Western culture there was a moral and a legal obligation for adult children to support needy parents There was also the expectation on both sides of mutual help and care in times of illness and disability The system of reciprocal services among relatives was particularly strong among the members of the extended family The feelings of obligation on the part of adult children to support and care for aging parents has declined with the establishment of social insurance and of medical and other community services

ITALY

The influence of the extended family is stronger in Italy, where the moral obligation of adults to support older relatives in need is binding than in any of our other five European countries of Western culture The strong sentiment of kinship makes for their willingness to support aging parents and other older relatives The Italian law gives sanction to these feelings which express the solidarity of the extended family It permits older persons if needy ' to claim aid from children and grandchildren from sons in law and daughters in law and from brothers and sisters ' (Colombo 1958 p 26)

In general this obligation to support parents is recognized and fulfilled But particularly in cities there is evidence that familial attitudes and sentiments are weakening The director of the Department of Public Assistance in Milan (Colombo 1958) states I can certify that very often some old and needy parents prefer to renounce aid from their descendants rather than to occasion painful and inhuman contests What father can agree to claim in the court against his children? Family duty in this matter is admirable only if spontaneous

FRANCE

The French law is similar to the Italian statute requiring adult children and adult grandchildren to support needy parents or grandparents Support of indigent parents and grandparents is recognized as a moral obligation and it is rare that children seek to evade this duty Sometimes a needy older person may have three children and

with children they rise to 42 and 46, respectively

In the DIVO-Institute survey older people were asked the question "With whom do you live in the household?" Their answers were classified as shown in Table 1 The differences in response by the sexes

one-fourth of the women (24 per cent) reside with spouse only In addition, 19 per cent of the men but only 9 per cent of the women live with spouse and others (children children in law grandchildren other relatives and non relatives) The proportion living with children is about the same or 29 per cent of the men and 32 per cent of the women. But 15 per cent of the men and only 7 per cent of the women live with spouse and children By contrast only 14 per cent of widowers but 25 per cent of widows are living with their children

Older and younger people in the country often work and live together They have one kitchen and eat at one table The grandmother takes care of the young children

When the old father feels physically failing he turns over the management of the farm to his son Often he delays this change until he is 70 or over The son who is carrying on the major farming activities cannot do anything without the approval of the older man

Since he is the owner of the farm the father has a strong influence on the selection of mates for his grandchildren In one case an old farmer disapproved of the marriage of a granddaughter to a young man from the next village because he did not have enough ground underfoot. The girl did not marry this suitor

The new insurance system for farmers may relieve the situation by inducing farmers to retire when they reach 65 The son will take over management of the farm at an earlier age and introduce new methods of agriculture which his father opposed

In Germany there is now a strong trend for older people to live by themselves They wish to become independent of their children and this is encouraged by the recent liberalization of old age insurance, and this trend is also welcomed by their married sons and daughters There is a growing tendency for the aged couple to remain in their home and for the children at marriage to move into new housing

TABLE 1*

ANSWERS TO QUESTION, "WITH WHOM DO YOU LIVE IN YOUR HOUSEHOLD?"

Answer	Per Cent	
	Men	Women
Alone	13	30
Only with spouse	47	24
Only with spouse and children	11	4
Only with spouse children and children in law	1	2
Only with spouse children children-in law and grandchildren	3	1
With spouse and other relatives or non relatives	4	2
Only with children	6	11
Only with children and children in law	2	5
Only with children and children in law and grandchildren	4	7
With children and others	2	2
With other relatives or non-relatives	3	8
Not stated	4	4
Total	100	100

* Source DIVO-Institute, Frankfurt am Main

The custom of parents and adult children living together in West Germany is still characteristic of rural areas The Darmstadt Community Survey (Baumert 1954) reports that the three and even the four generation family was found in 42 per cent of all full time farm families in the area studied This type of large household however, was present in only 16 per cent of the part time farm families in 9 per cent of non farm units residing in rural communities, and in 5 per cent of families living in the city DIVO-Institute reports that only 8 per cent of older people live in the

tant to distinguish those cases where the grown up children live with their parents and those where the aged couple live with their adult children

Where the grown up children live with their parents, the older generation takes the dominant role The aging mother, if physically able, is in charge of the house keeping This arrangement proves more satisfactory to the older generation than to the young married couple In general, it works better if the daughter and her hus band live with her parents than when the couple live with the husband's parents

If the aging individual or couple live with a married son or married daughter the arrangement is generally difficult on both sides It is likely to be especially frustrating to the older generation who frequently feel in the way and useless In certain families, particularly those of higher income, a room with at least limited house keeping equipment is provided the old fa ther and mother or widowed parent

ENGLAND

Townsend (1957) states on the basis of a 1 per cent sample that at least 40 per cent of persons 60 years of age and over in Great Britain in 1951 were living with unmarried or married children or both A study showed that in 1947 almost 50 per cent of old people in Wolverhampton were sharing a home with their children (Shel don 1948)

In Bethnal Green Townsend (1957) found that 42 8 per cent of a sample of 203 people of pensionable age and their children were living together But less than a fifth—19 2 per cent—lived *with* their married children If only those with sur viving children are considered the corre sponding percentages are somewhat higher —52 1 and 23 3

The attitudes against aging parents and their married children living together is much stronger than might be expected from the percentage who actually reside with them In Bethnal Green, for example only 10 per cent of older parents with sur viving children were in favor of it Of those living together with their married children only 33 per cent approved of the arrange ment (Townsend 1957) They gave as their reasons against it the desire for in dependence, privacy, and non interference in the lives of their children They also emphasized the danger of conflict with the children's spouses There seemed to be sev eral reasons why married children and par ents lived together Older people more often lived with married daughters than with sons Sons or daughters who were only children were more likely to continue to live with parents after marriage widowed more than married older people resided with married children The preferred ar rangement frequently expressed was to live near but not with the married children

Of those with surviving children 52 per cent lived with children and 33 per cent had children living within a mile—a total of 85 per cent living with them or living not more than a mile away Fifty per cent of all the children lived within a mile Only 11 per cent lived outside London

With children who lived nearby contacts were frequent Old people saw 26 per cent of their sons and 45 per cent of their daughters daily For at least once a week or more but not daily the corresponding figures were 42 per cent and 33 per cent Not seen at all during the year were 4 per cent of the sons and 2 per cent of the daughters (Townsend 1957)

WEST GERMANY

Many older parents live with children or vice versa partly because of the housing shortage due to destruction of buildings during World War II and partly to the influx of refugees from Poland and East Germany A survey by DIVO Institute,[2] Frankfurt am Main, reports that 36 per cent of older men and 38 per cent of older women live with at least one child If these percentages are calculated only for those

[2] DIVO Gesellschaft für Markt , Meinungs-, und Sozialforschung (an organization for market opinion and social research) Frankfurt am Main

riage, less than 30 went to reside in their own dwelling, about 40 went to the husband's home, and a little more than 30 took up residence in the wife's home In certain rural areas of Italy joint households are formed by married children living with their parents The paterfamilias maintains his authority, although he is out of touch with recent agricultural techniques "As he grows old he is usually helped by the oldest son, or by the one most able in business The wife directs the housework and is often at odds with the daughter in law because of the diversity of habits and the general differences in view of the generations" (Gini and Caranti, 1954, p 358)

THE NETHERLANDS

In the Netherlands the obligation to offer a widowed mother or father a home is generally recognized in the cities as well as in the country The son or daughter will ask a parent or parents, "Do you want to live with us?" There has been some tendency to have the aged father rotate in his stay with the different children This is particularly true if he is a nuisance and if the children feel that they must share the burden

At present in the cities and generally in the country the nuclear family of husband, wife and children (called *Gezin* in the Netherlands) is the predominant form But there still remain survivals of the traditional three generation family in eastern parts of the country Hofstee and Kooy (1956) point out that in the isolated rural region along the German boundary the traditional household may contain (*a*) several nuclear families, (*b*) a nuclear family and one or more individuals who are not members of a *Gezin*, (*c*) two, and possibly more nuclear families and one or more individuals and (*d*) two or more individuals

Hofstee and Kooy obtained data on the structure of the household on 497 farms at Winterswijk, situated near the German border Of these, 252 were cases of the nuclear family, and the remaining 245 were classified as traditional families In 125 of the traditional households a married couple lived together with the parents in-law, and in 100 cases a married couple and a father or mother of the husband or wife resided together A nuclear family and uncle were found dwelling together in 14 cases and a nuclear family and an aunt in 6 cases The old idea of primogeniture still prevailed, with the eldest son inheriting the farm He accepts the duty to compensate the other children and "to bring his parents to their end"

TABLE 2*

LIVING ARRANGEMENTS OF 831 MEN AND 1127 WOMEN 65 YEARS AND OVER MILAN, ITALY

With Whom Living	Persons 65 Years and Over (Per Cent)	
	Men (N = 831)	Women (N = 1127)
Alone	7 6	20 3
With spouse	45 4	18 6
Spouse and one or two children	20 1	8 0
With son	3 0	11 0
With daughter	6 2	13 4
With children	1 7	3 0
With married children	6 1	9 9
With one or two relatives	4 8	9 3
With others	2 6	2 8
No reply	0 2	0 1
Total	100 0	100 0

* Source S Ingegneros, *Aspetti gerontologici Milanesi* (Milan Commune di Milano 1958) Table 7

Outstanding features of the traditional household are as follows (*a*) the education of the child is conducted by his parents, his grandparents, and by his unmarried uncles and aunts living in the household, (*b*) if the young married couple live with the husband's parents, his wife has to subordinate herself to his mother as the mistress of the household, (*c*) if the young married pair live with the wife's parents, the husband has to subordinate himself to her father, "who will claim to be the 'farm

three generation family for their sample The extended family in the rural area has the locus of authority and influence in the grandfather

FRANCE

In 1946 a nation wide poll on aging was made (Girard 1948) which covered 904 persons retired or pensioned of whom only 23 per cent were under 60 years and 1561 employed individuals of whom 14 per cent were over 60 years with the remainder being 20–59 years old In answer to the question 'Are you living alone or with your spouse or are you living with your children? the following responses were received from retired or pensioned persons with children alone 40 per cent with children 39 per cent and no reply 21 per cent

Employed persons with children were asked, 'Do you intend to live alone later on or with your children? They gave the following replies alone 50 per cent with children 23 per cent and no reply 27 per cent

The large proportion of non replies in the two groups makes it difficult to interpret the findings At any rate a large percentage of retired or pensioned older people and their children are living together

Tréanton (1959) reports that, of 101 subjects with a child living in Paris in his sample of aged workers the child in 48 instances resided in the same dwelling or house as the parent and in 22 other cases in the same neighborhood or district

But the younger generation in the city follows the principle that the generations must have different homes In the lower class the ties are strong between the generations The older person in the city seldom lives with the children In Paris the young people have very small houses, and most of the cases of living together are of young people living with parents Seldom do the parents reside with their children The rents are under control at fixed prices Old people keep their flats and, since it is almost impossible to get housing the young people who marry cannot find accommodations So they move in with their parents "Young couples dislike living with their parents or 'in laws' which the housing shortage forces them to do, they do not hesitate to sacrifice their comfort in favor of their independence" (Ceccaldi, 1954)

There are two differences between France and the United States there is close proximity of the two generations in France and there is low geographical mobility People do not want to leave their province because of the difference in type of living among the provinces France, composed of areas of different types of nationalities has different styles of living

In the country the traditional custom of married children living with parents is still maintained (Ceccaldi, 1954), and farming is an extended family affair Agricultural economy rests on 'family stock" including three generations and sometimes more placed under the almost patriarchal authority of the owner aided by at least one of his children generally the eldest who will succeed him by the spouse of the latter and by their children Even in rural France the large family ties are relaxing in their place is the development of friendship and neighborly relations and mutual aid

ITALY

The study of older persons in Milan yields data on the proportion of men and women 65 and over who are living with their children The living arrangements are shown in Table 2 The percentage of the older people living together with their children is 37 for the men and 45 for the women These percentages are quite close to those reported for England and West Germany and they would undoubtedly be higher for all Italy with its large rural population

Gini and Caranti (1954) report that the housing shortage after World War II forced many young couples to double up with their parents From 1948 to 1950, of 100 couples in Rome with known street address at mar

ropean studies present data on the number of contacts of older persons with their children

Townsend (1957), in his study of Bethnal Green, gives the most exact breakdown on the frequency of children's contacts with older people (Table 3) He observes that children may be divided into three groups by the frequency of contact intimates (seeing each other every day or nearly every day), week-enders, and holiday companions (those living at a distance but attending weddings, funerals, and golden wedding anniversaries) He also notes the regularity of the visits between parents and children

The survey of attitudes of older persons conducted by the Swedish Institute of Public Opinion Research reports findings for

TABLE 3*

FREQUENCY OF CONTACT WITH SONS AND DAUGHTERS
GREAT BRITAIN

Frequency	Per Cent
Daily	36
Not daily but at least once a week	38
Not weekly but at least once a month	17
Not monthly but at least once a year	7
Not seen	3

* Source P Townsend, *The Family Life of Old People* (London Routledge & Kegan Paul, 1957)

TABLE 4*

FREQUENCY OF CONTACT WITH SONS AND DAUGHTERS
SWEDEN

Frequency	Per Cent
Daily or nearly every day	59
At least once a week	20
At least once a month	12
Not monthly but at least once a year	9

* Source Swedish Institute of Public Opinion and Research *På Äldre Dagar* (Stockholm The Institute, 1956) Question 15a

men over 67 on the frequency of seeing their children (Table 4) These findings agree in general with the data from Bethnal Green on the frequency of contacts of parents and children, although the answers were recorded somewhat differently

Even more detailed findings for a nation wide sample of 366 older men and 455 older women in West Germany are reported by DIVO Institute, Frankfurt am Main (Table 5) As in the other studies, the percentages are for those with living children or stepchildren These figures correspond rather closely with those from England and from Sweden They also indicate only small differences between men and women

TABLE 5*

FREQUENCY OF CONTACT WITH SONS AND DAUGHTERS
WEST GERMANY

Frequency	Per Cent	
	Men	Women
Often because live with children or stepchildren	42	46
At least once a week	29	30
At least once a month	11	12
At least once every 6 months	8	5
Once a year	4	2
Only every second year	2	1
Generally none	1	1
None	2	2
Total	99†	99†

* Source DIVO-Institute Frankfurt am Main
† Differs from 100 owing to rounding error

TABLE 6*

FREQUENCY OF CONTACT WITH SONS AND DAUGHTERS
FRANCE

Frequency	Per Cent
At least once a week	59
From time to time	32
Rarely	9

* Source J R Tréanton Adjustment of Older People to Urban Life in France, in C Tibbitts (ed) *Aging and Social Health in the United States and Europe* (Ann Arbor Division of Gerontology University of Michigan, 1959) p 172

Tréanton (1959) in his study of old age pensioners in Paris secured data on frequency of contact between children and the 101 parents who had at least one child living in Paris (Table 6) The frequency of contact of older persons in Paris with their

er' until his last gasp of breath", and (*d*) the married person who lives with his or her parents is likely to be kept in the position of a "child" until his old age At present tensions are developing in the traditional family because of the conflict between the old forms and norms and the wishes and desires of the younger generation resulting from contact with modern culture

SWEDEN

The national opinion study of older people (57–67 and over 67) provides data on living with children and attitudes toward this housing arrangement (Sweden's Institute of Public Opinion Research 1956) Of those 57 and over, 6 per cent report that they live with children But this proportion is only 3 per cent for the age group 57–67 but jumps to 11 per cent for the age group over 67

In answer to the question ' Do you think it is all right for a person over 65 to live with his children?" 29 per cent of those 57–67 years of age and 38 per cent of those over 67 years of age give favorable replies The corresponding percentages for those opposed are 39 and 32 The others are doubtful When, however, persons are asked the housing arrangement they would prefer, only 2 per cent of them 57–67 and 3 per cent of those over 67 reply 'with or near children" The desire to live independently is very strong in Sweden

C Parent Child Relations

In the extended family the relations between the older and younger generations are close and satisfying The aging parents are the authority to whom the son and daughter, even after marriage, turn for advice and with whom they are generally in regular and intimate contact

Relations of parents with daughters and sons—In working class neighborhoods the relations between parents and their married daughters are stronger than those between parents and their married sons Young and Willmott (1957) present statistical evidence to support this generalization

> A greater proportion of both youngest and only married daughters live with parents
> Married women live nearer to their parents than do married men
> Married women see both fathers and mothers more often than married men see their parents
> Married women see their mothers more often than their fathers
> Married women living nearer see their mothers more often than those living further away
> Men see their mothers in law more than women see theirs [pp 220–21]

The strongest relation in the extended family is that between "Mum" and her married daughters As soon as the married daughter leaves work to have children, the ties with her mother are greatly strengthened In fact, she seems often to be much more a member of her mother's family than the mistress of a new family Young and Willmott (1957) speak of the great triangle of adult life as "Mum wife-husband" Often there is avoidance of the mother in law by the son in law Of 26 married men in their sample, they found 17 drawn into the extended family of the wife and 9 who stayed out of it One Mum" spoke of the latter as "out laws" in distinction from "the in laws (Townsend 1957)

The relation between the older mother and her own son is a close one He visits her regularly but generally without his wife

Townsend (1957) sums up most of the characteristic features of the relationship between aging persons and their married children and children in law as the special tie between mother and daughter, the way married sons visited their parents unaccompanied by their wives, the tactful avoidance of children in law the tensions between in laws, particularly between husband and mother in law, and the close relationship between maternal grandmother and grandchild ' (p 85)

Frequency of seeing children—Four Fu

ices of the welfare state which enabled the daughter to start her married life on a material plane higher than that attained by the mother until after many years of marriage and (4) the outmoding, in the eyes of the modern generation of the advice which the mother could give In short the traditional Mum role was passe and the mothers in their later years were left without a function in the lives of their daughters

Drinkwater s findings are questioned by Townsend on the ground that they were obtained from special groups of women who were members of clubs and not from a representative sample He also notes that views publicly expressed in a club are very different from those voiced by a person in his own home

The relation of father and grown up son had never been so close as mother and daughter or even so close as mother and son It had perhaps been closest where the son followed in the same occupation as the father Bosanquet (1906) points out that before the industrial revolution a general pattern was the succession sometimes for generations of father and son in the same [illegible] son of skill

father s occupational knowledge In present-day England the role of the older man as authority and advice-giver to his son has declined to the vanishing point.

The extended family as a cohesive social unit seems on the way out This process is hastened in England by the policy of housing authorities to give preference in the new housing developments on the basis of need They do not take into account family relationships or attempt to resettle the extended family as a group project Probably "Mum would oppose any such move The alternative would be to remodel the old dwellings on the East Side

Perhaps we should use the term the 'kinship network" (Bott 1957) to describe the relations of older persons with relatives where there is no extended family or where it has ceased to exist In this way each person would have a kinship network that would generally be unique to him and not fully shared by other persons

D Grandparent Grandchildren Relations

The increase in the proportion of older persons in the population of countries of Western culture living beyond age 65 means that in 100 years the chances of a child s having a grandparent have doubled The decline in fertility during the same period results in a smaller number of grandchildren In completed families the average number of children was more than cut in two in Bethnal Green in one generation (from 5 8 children for marriages in 1900–1909 to 2 5 children in marriages in 1920–29) The corresponding decline in Great Britain was 32 per cent (or from 3 4 to 2 3 average number of children) (Young and Willmott 1957)

ENGLAND

In the Bethnal Green sample, Townsend (1957) reports that 14 per cent of old people lived in a three-generation home But married couples almost invariably constituted separate households and had their own kitchen

Almost all the old people (93 per cent) with children had at least one or more living in Bethnal Green There was a total of 908 grandchildren

Although grandparents had been strict with their own children they were generally lenient with grandchildren This was observed by Townsend (1957) and by Young and Willmott (1957), who also studied family life in Bethnal Green The latter offer an interesting explanation of the difference in the role of the grandparent and the parent in relation to the child

They note that parents are the authorities for the children with the primary responsibility of teaching them right conduct The grandparents are more easygoing They

children is less than that given for England, for Sweden, and for West Germany Over two thirds of the children live with or near their parents (48 per cent in the same dwelling or the same household and 22 per cent in the same or nearby district)

The findings from these four separate studies in different countries support the conclusion that family contacts are frequent in European countries of Western culture and play a part in maintaining family relationships between the older and the younger generation

Ceccaldi (1954) reports the decline of gatherings of the extended family They occur ' only during vacations and for the great religious festivals Christmas Easter, baptisms, first communions marriages funerals, anniversaries are generally celebrated in a more intimate circle "

Effect of residential mobility on contacts —This system of family relations is disrupted when a family moves from a long established working class neighborhood into a better residential district Distance greatly diminishes social contacts and upsets the customary program of reciprocal services ' Mum ' loses her traditional role and central place of authority and dispenser of advice

Twenty miles away from Bethnal Green is the new housing estate of Greenleigh to which many residents of East London have migrated Bethnal Green has lost nearly half its residents to this and other residential suburbs on the outskirts of London What have been the effects of this movement of population on family and on husband wife relations? Young and Willmott (1957) interviewed 47 former Bethnal Green residents to find the answer

The original decision to move was a hard one The attractions were a fine new house with a garden, with fresh air and space to play for the children But, from the opening of the Greenleigh estates until 1956, 26 per cent of the tenants had moved back to the East End

The move to the suburbs weakened the extended family and strengthened the husband wife relationship and a companionship relation developed There is the distance, the time, and the cost of trips The average number of contacts is cut to one-seventh for the wife and to nearly one fifth for the husband The husband s contacts are higher than the wives' because many return daily to work in Bethnal Green

Because of the higher cost of housing and transportation to work, the husband economizes by giving up or reducing his drinking and his attendance at the pub and at sporting events Husband and wife stay home at night and watch television which is in two thirds of the homes instead of one third as at Bethnal Green A smaller proportion at Greenleigh have relatives to care for children at time of confinement of wife

Drinkwater (1959) in his study of 550 working and lower middle class women aged 45–60 discovered evidence of the transformation which he believes is now taking place in England in the relationships of older women to married daughters His respondents were members of women s clubs which indicated that they were already detached from or never were members of the extended family These older women as a group expressed feelings of resentment and hostility to the recently married They spoke of these welfare state marriages or "postwar marriages '

They had bitter comments on their rejection by their daughters on marriage epitomized in the statement ' We never treated our mothers in the way we are treated by our children We may have differed from them, but we *respected* them We did not leave them in the lurch and then set ourselves above them " Drinkwater explains the sources of this attitude (1) the expectation of the mothers to play the "Mum role of confidante and adviser to their daughters after marriage, (2) the frustration of this expectation because of the new relation of companionship and partnership in marriage in which the wife turned to the husband rather than to her mother, (3) the prosperity and the serv

FRANCE

There is a close relation of grandparents with grandchildren if they live near each other Parents often send their children for the night to the grandparents who are happy to have them They do this when they want to go out for the evening or when the wife is sick or pregnant When grandparents are living in the provinces grandchildren are sent to them for the holidays Well to do grandparents often build a house in the country and count on having their grandchildren with them during the holidays The parents may then be free to take short trips without the children Because of their peasant origin many city workers send their children to the ancestral peasant home for the holidays

THE NETHERLANDS

The celebration of birthdays is important and is the occasion for family reunion of grandparents children and grandchildren

III Husband Wife Relations

A Economic and Social Trends

Husband wife relations in northwestern European countries are in a process of change Certain of these changes are the res lt of econom-

FRANCE

The Latin system of husband wife relations is general and persists with little or no change The husband has the conception of being the master The wife never makes decis ons but lets the husband make them No real change in authority is taking place

Where the wife works with the husband she is under his complete authority On the farm the paternalistic system of authority governs the members of the family This system is also very frequent in small businesses The ideal objective is for a young man to obtain a small business in which his wife often works with him She is thus in continuous contact with him but under his authority

ENGLAND

In working class families in an industrial residential neighborhood the relation of husband and wife typically seems to be that of competitive co-operation rather than companionship The aging husband finds companionship not so much with his wife as with friends at work or in the pub or at sporting events The wife experiences companionship with her daughters and female relatives more than with the husband

The data from Bethnal Green give support to this theory Wives seldom knew what the husbands earned Only seven of thirty four wives who were asked knew the husband s earnings On her part the wife does not often tell the husband what her income is from lodgers from payments by children living in the home or from contributions from children and relatives living outside (Townsend 1957)

The traditional division of roles is for the husband to be the sole or chief bread winner and to be consulted on any crucial decision and for the wife to have full charge of the domestic economy Their social life is also segregated The leisure time of the husband is spent in going to pubs sport grounds and clubs with brothers or work mates In her free time the wife joins her daughters or sisters in attending movies or clubs The sexes are also segregated in old people's clubs or in outings

B Retirement and After

What changes take place in the relations of husband and wife after retirement from work? Retirement (or the acceptance of a job of lower status) is a crisis for husband and wife There is the reduction in income which generally requires drastic cuts in expenditures In all countries of Western

state that the generalization of Ratcliffe Brown about the relationship of grandparents and grandchildren in Africa as one "of friendly familiarity and almost of social equality" surely applies to Bethnal Green But parents often feel that the grandparents are too indulgent

Grandparents in Bethnal Green performed many services for their grandchildren (The average age of becoming a grandmother or a grandfather was 53 and 55 years, respectively) Sixty three per cent of grandmothers regularly would help in taking them to school, giving them meals

TABLE 7*

Older Persons with One or More Grandchildren, West Germany

No of Grandchildren	Per Cent	
	Men	*Women*
One	11	12
Two or more	59	56
None	24	27
Respondent had children	(15)	(18)
Respondent had no children	(9)	(9)
Not stated	6	5
Total	100	100

* Source DIVO-Institute Frankfurt am Main

and looking after them when their parents were at work or went out in the evening Twenty per cent of grandfathers would *regularly baby sit or bring grandchildren* from school or go with them on trips to the park (Townsend, 1957)

The important role of the grandmother in the rearing of children can hardly be overemphasized The first grandchild, particularly the eldest child of the oldest daughter, was the object of special attention and affection by the grandmother Often the grandmother was as much concerned with the care of young children as the mother Sometimes the grandmother would have main charge and occasionally full charge of a grandchild This close relationship of the grandmother with grandchildren helped markedly in maintaining and extending the ties of the extended family

WEST GERMANY

Over two thirds of older persons have one or more grandchildren (70 per cent of the men and 68 per cent of the women) according to the DIVO Institute survey The detailed figures are given in Table 7

"In his relationship with his grandchildren a German may be freer and more indulgent than with his own children, he behaves more like the American father, and is more relaxed, reciprocal and joyful Possibly this is due to the fact that he is not responsible for the education of his grandchildren, he depends on his son to be the stern father and an example to them" (Schaffner, 1948)

The grandmother still has a function in *the possibilities of caring for the grand* children Her care of the grandchildren may lead to conflict if she is with them every day If she tries to raise or educate them, tension is likely to arise with her daughter or daughter in law In a mutually satisfactory arrangement the grandmother looks after the children when the parents lack the time or when they go out for the evening or on a holiday trip

The progress of technology and the introduction of laborsaving devices into the home have limited the former activities *performed by the grandmother* for her children and grandchildren In the past, if a stocking had a hole, the grandmother would darn it, now, with nylon, this can not be done This illustration symbolizes the way in which technological advances diminish the household function of grandparents

It can, of course, be argued that some technological changes provide new chores for grandparents—such as taking children to the cinema, viewing television with them, or mending their roller skates or toy shot guns The real question is to determine the net effect of technological inventions

across the married, the widowed, and the divorced. Old age and retirement bring special problems to these groups of the aging population.

A. The Widowed and Desolation

The widowed constitute a high proportion of persons 65 years and over in Western countries as indicated by Table 8. In all six countries the proportion of widows is much higher than of widowers. It is over twice as high in France and Italy and nearly double in the United Kingdom and West Germany. In the Netherlands and Sweden the percentage of widowers is only one third less than that of widows.

The proportion of widowers is remarkably the same for the six European countries for which statistics are available. By contrast the proportion of widows varies widely from 42.0 per cent in Sweden to 57.9 per cent in France. This difference is partially to be explained by the fact that France has a lower proportion of males 65 and over in the population (40.3 per cent) than Sweden (46.7 per cent). Probably husbands killed in World War I contributed to this excess in percentage of widows. The two countries that were not involved in this war have the lowest percentage of widows 65 and over (the Netherlands 44.1, Sweden 42.0).

The two chief crises in the life of a woman in the later years occur when children leave home and when her husband dies. Widowers remarry but the majority of older widows remain husbandless.

Where the external maternal family survives with "Mum" at its center, the marriage of children is not a catastrophe to the older woman so long as they remain in the neighborhood. Her tie with her daughter is even stronger than before. She now has a satisfying function for her later years in relations with her daughters, sons, and grandchildren. The crisis occurs when the extended family breaks up and the dyad relation of companionship of the married pair develops.

In Great Britain just under one-half of the women 65 years and over (48.7 per cent) are widows, and one in four of the men in this age group are widowers. The proportion, of course, is lower in the age group 65–69 and increases with age. A main point of interest is the question of who suffers more in widowhood, the man or the woman. Measures of the effects of bereavement may be found in changes in contacts with children, in self reports of loneliness, and in mortality and suicide rates.

1. *Contacts with children.*—The Bethnal Green study indicated that the widowers saw their sons and daughters less often

TABLE 8*

PERCENTAGE WIDOWED OF POPULATION 65 AND OVER IN SIX COUNTRIES

Country	Year	Male	Female
France	1954	23.7	57.9
Italy	1951	25.4	54.8
The Netherlands	1947	28.4	44.1
Sweden	1950	26.8	42.0
United Kingdom	1951	25.5	48.5
West Germany	1950	28.8	56.0

* Source: United Nations, *Demographic Yearbook, 1955*, Table 6.

than married men saw their children. Widows, however, had slightly less frequent contacts than married women with their daughters but about the same with their sons (Townsend, 1957).

2. *Loneliness.*—In the Bethnal Green study 46 per cent of widowed people said that they were very or sometimes lonely, as compared with 27 per cent in the total sample. Townsend (1957) found that loneliness was related definitely to desolation, particularly by the loss of a spouse. He shows that the feeling of loneliness varies directly with the recency of bereavement. The percentage of those reporting loneliness is 93 within 4 years of death of spouse, 50 within 5–10 years, and falls to 27 after 10 years (or the same percentage as for the total sample).

Treanton (1959) found in his study of

cultures there is the loss of status of the husband in the home and in the community. This drop in prestige and in self-respect varies from country to country and by class position.

ENGLAND

Husbands in Bethnal Green looked ahead to retirement with anxiety and fear. Therefore, they continued working as long as they could at their old job and took new employment even at a lower wage. Their status in the home and in the community was lowered when they retired and even when they changed to a part-time or full time job of an unskilled type and less pay. The men continued to work as long as they could and then retired or were retired because of their health. Only 9 per cent retired from full time work with choice as their sole reason (Townsend, 1957). The others generally tried to find lighter jobs.

Retirement lowered the husband's standing in the family. He felt keenly the loss of income, the boredom of nothing worth while to do, the feelings of uselessness and not being wanted, and the fear of becoming a burden on his children and other relatives. He had no substitutes for the satisfactions which he had obtained from work. He lost his friends at work and felt snubbed by old friends in the community. He had made no plans for retirement.

Employed women retired from work at an earlier age than men and more frequently by choice. They did not feel giving up their jobs as keenly as men because they had a useful function to perform in the home and because employment was seldom as absorbing an activity as it was typically for men.

In general, life goes on in the Bethnal Green family the same after as before retirement. There is little change in the proportion of men who assist the wife in household tasks. The amount of help a husband gives his wife depends largely on the absence of daughters in the home or within a five minute walk (Townsend, 1957). Husband and wife generally pursue their separate social interests rather than engage more in joint activities. They do not seem to get closer together after retirement.

Indeed, there may arise new sources of friction. Minor irritations increase because of reduced income and the often unwelcome presence of the husband in the home. He feels keenly his loss of standing with his wife and children. One in five of the married women disclosed marked marital conflicts. Part of these may be due to sexual dissatisfactions, especially in cases of the frigidity of the wife due to infirmity.

THE NETHERLANDS

The older man on retirement does not lose status to the same degree as in certain other countries. This is due in large part to the respect paid to old age. It is customary for young people to give up their seats in streetcars to older men and women.

WEST GERMANY

There is no expectation that the older person after retirement should be very active (Baumert, 1957). The traditional philosophy is that a woman should grow old gracefully and reduce her activities. The expectation of the lower middle and upper lower classes is that the retired man should have a hobby and should work a little in his garden. He should meet with his little club (*Stammtisch*) at a table in the restaurant or *Bierstube* where he and his friends usually sit.

The extended family is at the center of interest of older persons. The retired person maintains his associations with relatives, particularly with his children and grandchildren.

IV. The Widowed, the Divorced, and the Single

So far we have considered the family relations of the married and those living with their spouses. Little or no attention has been paid to single persons, the widowed and the divorced, nor has there been any discussion of the childless couples who cut

across the married, the widowed, and the divorced Old age and retirement bring special problems to these groups of the aging population

A The Widowed and Desolation

The widowed constitute a high proportion of persons 65 years and over in Western countries as indicated by Table 8 In all six countries the proportion of widows is much higher than of widowers It is over twice as high in France and Italy and nearly double in the United Kingdom and West Germany In the Netherlands and Sweden the percentage of widowers is only one third less than that of widows

The proportion of widowers is remarkably the same for the six European countries for which statistics are available. By contrast the proportion of widows varies widely from 42 0 per cent in Sweden to 57 9 per cent in France This difference is partially to be explained by the fact that France has a lower proportion of males 65 and over in the population (40 3 per cent) than Sweden (46 7 per cent) Probably husbands killed in World War I contributed to this excess in percentage of widows The two countries that were not involved in this war have the lowest percentage of widows 65 and over (the Netherlands, 44 1 Sweden 42 0)

The two chief crises in the life of a woman in the later years occur when children leave *home* and when her husband dies Widowers remarry but the majority of older widows remain husbandless

Where the external maternal family survives with 'Mum' at its center the marriage of children is not a catastrophe to the older woman so long as they remain in the neighborhood Her tie with her daughter is even stronger than before She now has a satisfying function for her later years in relations with her daughters, sons and grandchildren The crisis occurs when the extended family breaks up and the dyad relation of companionship of the married pair develops

In Great Britain just under one-half of the women 65 years and over (48 7 per cent) are widows, and one in four of the men in this age group are widowers The proportion, of course, is lower in the age group 65–69 and increases with age A main point of interest is the question of who suffers more in widowhood, the man or the woman Measures of the effects of bereavement may be found in changes in contacts with children, in self reports of loneliness, and in mortality and suicide rates

1 *Contacts with children*—The Bethnal Green study indicated that the widowers saw their sons and daughters less often

TABLE 8*

PERCENTAGE WIDOWED OF POPULATION 65 AND OVER IN SIX COUNTRIES

Country	Year	Male	Female
France	1954	23 7	57 9
Italy	1951	23 4	54 8
The Netherlands	1947	28 4	44 1
Sweden	1950	26 8	42 0
United Kingdom	1951	25 3	48 5
West Germany	1950	28 8	56 0

*Source United Nations *Demographic Yearbook* 1958 Table 6

than married men saw their children Widows, however, had slightly less frequent contacts than married women with their daughters but about the same with their sons (Townsend, 1957)

2 *Loneliness*—In the Bethnal Green study 46 per cent of widowed people said that they were very or sometimes lonely as compared with 27 per cent in the total sample Townsend (1957) found that loneliness was related definitely to desolation, particularly by the loss of a spouse He shows that the *feeling* of loneliness varies directly with the recency of bereavement The percentage of those reporting loneliness is 93 within 4 *years* of death of spouse, 50 within 5–10 years, and falls to 27 after 10 years (or the same percentage as for the total sample)

Treanton (1959) found in his study of

retired men in Paris that 41 per cent of the widowed as compared with 20 per cent of the married felt isolated to some degree

In a representative sample of 890 older persons in California 40 per cent of widows stated that they were often lonely, as compared with 16 per cent married and living with spouse only (Bond, 1954)

*TABLE 9**

DEATH RATES PER 1000 FOR MARRIED AND WIDOWED OLDER PERSONS

GREAT BRITAIN

Age	Males		Females	
	Married	Widowed	Married	Widowed
62	27	37	12	17
67	42	52	25	27
72	63	76	42	46
77	96	116	72	80
82	147	175	113	131

* Source Great Britain Registrar General *Decennial Supplement for England and Wales 1951*

3 *Death rates* —The general death rate is higher for the widowed than for married persons in old age The statistics given in Table 9 are from the Registrar General's Decennial Supplement for England and Wales, 1951 At every age the death rate is higher for the widowed than for the married and is much higher for widowers than for widows

4 *Suicide rate* —Comparative suicide rates are not available by country by age sex, and marital status Special studies of suicide indicate that they are higher among the widowed, the single and the divorced than among the married (Cavan, 1928, Dublin and Bunzel, 1933) Thus they may be taken as an indication of the conditions of life of members of these groups that lessen their hold on life The suicide rate (for the year 1955) for men was higher in the age group 65 and over as compared with the age group 45-64 (Table 10)

In England and Wales France, and the Netherlands the suicide rate for males increases markedly after 65 In Sweden and West Germany the increase is relatively small The suicide rate for women is uniformly much lower than that for men Except for France and the Netherlands it is only a little higher after 65 In fact, for Sweden it is somewhat lower

All these data—fewer contacts with children (for the widower), more loneliness higher death rate, and higher suicide rate—indicate the effect of the broken family relation upon the happiness and personal adjustment of the widowed The incidence of these indicators is much higher for widowers than for widows This fact strongly suggests that it is much harder for the widower than for the married man to make successful adjustments to the retirement crisis

TABLE 10*

SUICIDE RATE PER 100 000 BY AGE AND SEX IN FIVE COUNTRIES

Country	Males		Females	
	45-64	65 and Over	45 64	65 and Over
France	49 2	71 0	13 9	18 4
The Netherlands	15 5	32 2	10 5	15 0
Sweden	52 3	57 3	14 7	12 5
United Kingdom	25 7	43 5	16 7	17 4
West Germany	45 9	51 1	21 9	22 5

* Source United Nations *Demographic Yearbook 1957*

B The Single the Divorced and Isolation

The two smallest groups by marital status are the single and the divorced older persons While a minority of them live with relatives the majority live alone The data available on the single and the divorced in old age are largely limited to their numbers in the population, their isolation and loneliness and their care by welfare agencies

THE SINGLE

The percentage of single men and women in the population 65 and over varies considerably in the different selected countries of Western culture (Table 11) Sweden has

the highest rates of single men and single women and France and West Germany the lowest. The proportion of single women tends to be almost double that of single men except for Italy and the Netherlands, where it is about 50 per cent greater In all six countries the percentages of divorced is low for men and women and somewhat lower for males than females

In Bethnal Green (Townsend, 1957) many single persons were drawn into the three-generation family In the sample in the study most of the single persons had siblings Half of these lived with or near a brother or sister A special 20 per cent census sample of Bethnal Green gave 39 per cent of single women over 60 as compared with only 1 per cent of married women of the same age living with brother or sister Frequently the single person lived in the old home after the death of parents and received attention and care from a married sister The percentages of brothers and sisters seen daily and weekly by single persons was three to five times higher than the percentages seen by married or widows with surviving children

TABLE 11*

PERCENTAGE SINGLE OF POPULATION 65 YEARS AND OVER IN SIX COUNTRIES

Country	Year	Male	Female
France	1954	6 4	10 5
Italy	1951	7 1	11 5
The Netherlands	1947	9 0	13 2
Sweden	1950	12 9	20 9
United Kingdom	1951	9 0	16 6
West Germany	1951	4 4	8 5

*Source United Nations Demographic Yearbook 1958 Table 8

When single siblings were drawn into the three-generation family, they often gave more service than they received They might even take over roles like those of provider, mother, grandmother, or housewife In these cases they had close relations with siblings, nephews, and nieces

There are the isolated single persons who have few if any kinship ties. They comprise about 40 per cent of the bachelors and spinsters in Bethnal Green Studies in England (Sheldon, 1948) and in the United States (Bond, 1954) indicate that high proportions of the single as well as the widowed report themselves as lonely

The death rate per 1000 population of single men is higher than for married men as shown by the data from the Registrar General's *Decennial Supplement for England and Wales, 1951* (Table 12) The

TABLE 12*

DEATH RATE PER 1000 SINGLE OLDER MEN UNITED KINGDOM

Age	Single	Married
62	34	27
67	50	42
72	72	63
77	108	96
82	162	147

*Source Great Britain Registrar General, *Decennial Supplement for England and Wales 1951*

differences between single and married men are large but somewhat smaller at the ages shown in the table than the differences between the widowers and the married. The sudden crisis of widowhood seems more adverse to health than the problems faced by the single person

The death rate for single women is practically identical with that for married women at each age

Whatever measure of personal maladjustment is taken—isolation, loneliness, death rate or suicide—gives findings indicative of the social disadvantage of the single state These consequences may be averted when the single person maintains contacts and relations with members of his family like brothers and sisters, nieces and nephews

THE DIVORCED

The persons 65 and over who are still divorced are a small and selected group They comprise only a small percentage of those ever divorced, most of whom have married again The great majority of them

have been divorced for many years Except for the minority who have children, their status is in some ways much like that of a single person

The percentage of the divorced in the population is higher in some countries than in others (Table 13) Sweden has the highest rates of those divorced both for men and for women The United Kingdom, where it is still difficult to obtain a divorce, has the lowest rates for men and women

Where statistics are available, the divorced are found to have the highest percentage of the lonely In one study the lonely comprised 48 per cent of the divorced 40 per cent of the widowed and

TABLE 13*

PERCENTAGE DIVORCED† PERSONS 65 YEARS AND OVER IN FIVE COUNTRIES

Country	Year	Male	Female
France	1954	1 1	1 7
The Netherlands	1947	1 2	1 4
Sweden	1950	1 8	2 3
United Kingdom	1951	0 2	0 2
West Germany	1951	0 5	0 6

* Source United Nations *Demographic Yearbook 1958* Table 6

† Divorced includes those separated for the Netherlands and for West Germany

34 per cent of the single compared with 16 per cent of those living with spouse only (Bond, 1954) The suicide rate is also the highest for the divorced as compared with all the other marital statuses

Cavan (1928) interprets the low rates of suicide with the married as compared with the widowed and the divorced as owing to the relatively greater degree of incorporation into an intimate group which they experience " She continues

> Membership in a family group not only provides opportunities for expression of wishes otherwise difficult to obtain but also acts as a means of control over the member The widowed and divorced are in a particularly trying condition because their habitual life organization has been destroyed and they often suffer in addition from grief and in the latter case perhaps social disgrace [p 319]

V SOCIAL POLICY AND THE FAMILY

The changes in family relations as they affect the aging have been presented for the selected countries of Western culture In recent years there has been an increasing number of studies of old people in relation to their family life Have the research findings of these inquiries implications for social policy? What are the current trends in social policy as they react upon the family relations of older persons?

Three countries have been the most concerned about the aging in their family relations These are Great Britain, West Germany, and Sweden In a fourth country—Italy—attention is being given to the potentialities of the institutional care of the aged

A Great Britain

Studies by Sheldon (1955), Townsend (1957), and Young and Willmott (1957) show that the program of welfare housing is undermining the extended family They call for changes in housing policy and procedures that will enable the three generations to live close to one another

Dr Sheldon, in his study of Wolverhampton (1948), was the first to give detailed statistics of the proximity of the old to relatives He found that in at least 20 5 per cent of his sample the older persons and their relatives living separately functioned as one family

Townsend (1957), in his study of Bethnal Green, documents the reciprocal services of the older and younger generation He shows that older persons with daughters and other female relatives made the least claim on health and welfare services. He calls for a social policy that would keep the family together if only because of the lower cost to the state Older people want better housing, but they do not wish to be separated from relatives or to be uprooted from their old and familiar neighborhoods He recommends more conversion of old houses, both small and large, and more new building of old people's 'flatlets' and bungalows inside the city He believes that

"there is no justification for an attempt to supplant the family with State services" (p 203) Such services as needed should give support to the family Among his concrete recommendations for strengthening family relations are giving priority in allocating housing to the wishes of members of extended families to live near each other, the setting up of a comprehensive family help service to include care for the isolated and handicapped old, granting allowances for the constant attendance of the bedridden and housebound and integrating institutions for the old into the community and making them more homelike The general principle is "to prevent old people from needlessly becoming wards of the State, by helping them to be cared for in *their own* homes and whenever possible, by their families (p 203)

Young and Willmott (1957) also advocate a policy of building new housing around existing kinship groups They assert that the sense of loyalty to one another among the inhabitants of a place like Bethnal Green is not due to buildings It is due far more to *ties of kinship* and friendship which connect the *people* of one household to the *people* of another In such a district community spirit does not have to be fostered, it is already there. If the authorities regard that spirit as a social asset worth preserving they will not uproot more people but build the new *houses* around the social groups to which they already belong

Shenfield (1957) who recently completed a review of the social provisions for old age in Great Britain has made recommendations to carry out what might be called a policy of housing kinship groups She favors a mixed development. Individual or small groups of dwellings suitable for older persons would be placed among other types of housing, and some smaller dwellings suitable for older people might be introduced into large estates of three bedroom houses Then too, "a granny plus' flatlet might be added to some existing housing

It will be of interest to learn to what extent these implications from research on the significance of kinship relations for the care and happiness of older people will affect future housing policy in Great Britain There is no question but that the present housing policy is accelerating the decline of the extended family in working-class districts of British cities

It should be recalled that Great Britain has abolished the legal obligation of adult children to support their needy parents This places the question of economic contributions of children to parents purely in [illegible]

[illegible] services is having the older and younger generations live in proximity

B West Germany

As we have seen, the three generation family of the patriarchal type still survives in rural parts of Germany The Minister of Family Affairs advocates the strengthening of the family in part by restoring the role of the father and the effectiveness of extended family ties Some students of the family (Schaffner, 1948) perceive tendencies in this direction, others (Wurzbacher, 1951, Schelsky, 1953, Baumert, 1954) point [illegible] same [illegible] Weste [illegible] analyzes the changing roles of aging parents and their adult children and recommends that society and the state should take action to support the emerging companionship family

Family households in which three generations live together or in which the other relatives of the wife or the husband are included comprise a smaller and smaller percentage of all households. With this appears a whole *series of* consequences the ties with a larger circle of relatives become looser, the small family of the spouses with their children becomes more and more confined to itself, and the mutual dependence of this small unity of members

living together becomes greater No longer does the wife expect of the husband only that he provide well for the family and up hold its reputation the husband no longer expects only that the wife manage the household efficiently and offer him a pleasant home life Both expect of each other in *stronger degree than in a more institutionalized relationship* emotional affection

A modification in the role of the children also takes place because the *meaning of* children in the consideration of the parents so far as it concerns the future of the family has somewhat narrowed owing to economic and social circumstances For many families especially for those of the higher social strata the meaning of children rested on the fact that they would be heirs of the property and traditions of the family for families of the lower strata *that they would later play a role as care* takers of the old parents Often education in the family was especially directed to this point and the children were prepared for this role On the one hand however the inheritable property of the family became smaller and smaller and consequently the institution of inheritance less meaningful For this and many other reasons the idea of family traditions tends to vanish *On the other hand the care of the old* is taken over by the state more and more or by other institutions and thereby the meaning of the children as later providers is decreased Accordingly there also appears especially with the smaller number of children in the family emotional affection as a more determinate factor in the foreground without entirely suppressing the other factors

Through the steady decline of the patriarchal concept the place of the old in the family circle also experiences a modification more perhaps through the taking over of the care of the aged by other institutions Earlier it was customary for the old parents to live in the household of one of their children *and to be cared for by this* one, perhaps with the common support of all the children Today the old more often manage their own household and live on a pension Families have given up the duty of the support of the old people On the other hand the aged when their support is not furnished by property as is more and more the case today, are independent of *their children through* pensions or public support

The increasing occupational activity of *married women may work in* general against the loosening of the ties between parents and grandparents This comes about because in many cases the care of the household and of the children by the grandmother makes it possible for the wife to enter a gainful occupation outside the home The position of the old in the circle of the modern family is further strengthened through the economic independence of *the elderly persons who receive* pensions and therefore are not burdens on the family budget when taken into the family household The general trend however is toward the financial and social independence of the old with a weakening of ties with their children and grandchildren (Baumert 1956)

It should not be the task of a present public policy to attempt a restoration of *the former type of family life* rather public policy should promote the development of new forms of family partnership adapted to today s economic and social conditions (Baumert 1954)

C Sweden

In her book *Nation and Family* Alva Myrdal places a social policy for the aging family and the individual in the context of a social philosophy of the welfare state She perceives the competition between the children the potential producers of the future and the old whose productive life is behind them The economic burden of support of the young and the old falls upon the younger and middle aged adults *who are the producers of the present*

In adjudicating this competition Myrdal

tends to side with the children (1945) She believes, *for example*, that new housing should be for new families with children and that old housing should be reconditioned for the old especially since they are accustomed to the old type of housing She points out that the Population Commission, with its interest in children and the future, stopped the first proposal for new housing for the old in 1937 But 2 years later the Riksdag voted a grant for the erection and reconditioning of dwellings for pensioners. She predicts that, although rational considerations should support the program in the interest of larger new housing for families with children the natural sentimentality about the old and their voting power will win out.

Myrdal attributes the provision of social security by government to the old and other handicapped persons as a result of the breakup of the three-generation family which in the past offered protection to all its members Government was the one organization large enough to take over this function She also recognizes that social security for the old frees the nuclear family from heavy handicaps to its success and happiness If legal responsibility of the adult children to support aging parents was enforced it would place obstacles in the way of their marriage and especially be a deterrent to having children She believes that it is necessary to develop 'a complete scheme for the maintenance of old people before the new era in social policy can focus on children and family' (p 344)

Myrdal has pessimistic reflections on the political and economic effects of the increase in proportion of the older segment of the population She points out that old people in Sweden because of life-tenure and seniority control important administrative positions in public life She refers to census findings that persons over 50 years of age owned 69 5 per cent of all wealth and that those over 60 owned 43 S per cent although their percentage in the population was only 22 4 and 12 8 respectively Both because of greater power and greater numbers at the ballot, she feels the old will win the contest between the age groups She fears that 'it will become more difficult to be young in a society controlled by the aged' (p 89)

Guiding principles for the welfare and independence of older people have been formulated by an official committee and have been approved by the Riksdag

A committee of parliamentary members and experts appointed by the Minister of Social Affairs in 1952 to report on the care of the aged in Sweden submitted its findings and recommendations in 1956 On the basis of this

of the committee and called for the Riksdag s approval of directives for the future development of the care of the aged which the Minister of Social Affairs had drawn up These directives re emphasize the guiding principles which governed developments in the past ten years and aim at continuing improvements in line with these principles

'In the first place and to the largest extent possible measures for the care of the aged should aim at assisting the aged by all available means to live independent lives in their own homes as long as possible without excessive personal strain the committee stated in its report

The most important condition for attaining this goal is to meet the old people s economic needs In this respect, the Minister of

1948 with subsequent amendments and on compulsory sickness insurance in 1955 as well as through full employment which enables older people to earn an income until they reach

poverty but must meet the aged population s special requirements of housing personal attendance and service Housing of adequate standard is essential to enable aged people to live by themselves and to reduce the pressure on the resources of the municipal homes for the aged and other establishments the com

mittee pointed out emphasizing the importance of adequate housing facilities from the humanitarian and economic points of view [Adapted from statement by Dr A Berggren of the Royal Social Board Stockholm]

The Social Democratic party in Sweden seems determined to apply this policy to income maintenance It introduced a bill in the Riksdag to provide insurance benefits equal to two thirds of the highest 15 years of a worker s wage Its defeat led to the election in 1958 in which the Social Democrats increased their seats in the Riksdag but fell short of a clear majority By securing votes from the smaller parties they could remain in office and perhaps enact this legislation

Even without this new proposal Sweden and Great Britain have gone further than other countries in providing houses and other services that enable older people to live independently of their relatives if they so desire

D Italy

Angelo Pagani (1958) a sociologist and gerontologist has raised the question of the importance of residential institutions in the care of the aged On the basis of careful observation of the residents of an Italian institution in Milan (Institute Inabilia Lavoro dell E C A) he has outlined an inquiry not only of the personal causes but also of the influence of economic and social conditions determining institutionalization

He points out that in Italy seeking admission to a public institution is not unusual and carries with it no feeling of individual inadequacy or loss of dignity It is not the result of the absence of family solidarity but rather of economic insecurity The urban industrial worker at the end of his working life faces a crisis characterized by (1) a low level of living (2) individual and social isolation (the loss of the natural community on leaving the factory), (3) family dependence low personal status and moral and cultural dependence and (4) a difficult emotional situation due to his awareness of his dependence Admission to a public institution means a rational solution of his problem and an improvement of his position (1) his new relationships insure an apparently independent life and put an end to family dependence and (2) his participation in shared work gives him again a feeling of usefulness

Rejected by society the aged find or aim at finding in the institution the element of a complete society Entry into a new community of equals causes an enrichment of social life counterbalancing the negative effects of institutionalization such as loss of full independence and removal from home life (p 54) In short Pagani views the residential institution at least in Italy as meeting the economic and social conditions facing the urban industrial worker and as solving his personal needs

It may well be as Pagani suggests that the residential institution at present is more adapted than other types of care for the aged to the Italian situation Nevertheless basic research on the significance and potential of institutional care of the aged versus other forms of housing is highly desirable in all countries of Western culture

In Italy at present only 3 per cent of persons 65 and over live in institutions As Colombo (1958) points out in his book *Principles and Organization of Social Welfare* the extended family still provides them with the main source of support and social life Old people in the large majority live together with their children and grandchildren If physically able they are yet useful for factory and domestic activities and for this reason are closely incorporated into the family unit This situation is more evident in rural areas and in small centers but differs somewhat in the cities Especially in the largest cities many old people cannot for various reasons, live with children and relatives and prefer to have an independent home sometimes very small and simple Often living conditions are difficult and they are

obliged to rent an attic or a room under the staircase But in Italy, as elsewhere, this trend for an autonomous life is strong and is increasing as housing programs are developed

These brief statements of social policies for the aging obviously are not adequate to represent the trend of thinking about the care of older persons in these four countries They do, however, present contrasts of emphasis upon directions of social action and so may be helpful in attempts to formulate or to reformulate national policies for the aging in countries of Western culture

VI Conclusion

In this chapter the family structure and relationships of older people have been discussed in the context of economic and social change Under the impact of industrialization and urbanization the three-generation family has disintegrated as a household and as a unit of economic production At first, however, it continued as a closely knit social unit But now, with the development of new relationships between the generations adapted to the conditions of modern life, it is being transformed into a social network

References and Bibliography

ADORNO, T W, FRENKEL BRUNSWICK, ELSE, LEVINSON, D J, and SANFORD, R. M 1950 The authoritarian personality New York Harper & Bros

ARENSBERG, M and KIMBALL, S T 1940 Family and community in Ireland Cambridge, Mass Harvard University Press

BAUMERT G 1954 *Deutsche Familie nach dem Krieg* Darmstadt E Roether Verlag

——— 1956 The changing role of family members *In Studies of the family 1, 275–76* Tübingen J C B Mohr

——— 1957 A pilot study concerning the family and old age *in* Germany (Unpublished paper)

BOND F A., BARER, R. E., VIEG, J A, PERRY, L. B, SCOTT, A H., and LEE, L. J, JR 1954 Our needy aged a California study of a national problem New York Henry Holt & Co

BOSANQUET, H. 1915 The family London Macmillan & Co

BOTT, ELIZABETH 1957 The family and social network roles, norms and external relationships in ordinary urban families London Tavistock Publications, Ltd

BURGESS, E W 1955 Human aspects of social poli[illegible]
49–

BURGE[illegible]
family from institution to companionship New York American Book Co

CAVAN, RUTH S 1928 Suicide Chicago University of Chicago Press

[illegible]

ire, Editore

——— 1938 Budgetary surveys *In* The need for cross national surveys of old age, pp 22–26 Ann Arbor Division of Gerontology, University of Michigan

[illegible]

Conn

DRINKWATER, R W 1959 Some role problems of women in middle life and their implications for subsequent adjustment *In* Proceedings of the Fourth Congress, International Association of Gerontology, Merano Italy, 3, 452 59 Fidenza Tipografia Tito Mattioli

DUBLIN, L. I, and BUNZEL, BESSIE 1933 To be or not to be a study of suicide New York Harrison Smith & Robert K Haas, Inc

GINI C and C [illegible]
I[illegible]

GIR[illegible]
sc[illegible]
Vi[illegible]
tio[illegible]
tai[illegible] France.

GORER, G 1955 Exploring English character London Cresset Press

HOFSTEE F W [illegible]
tiona[illegible]
surv[illegible]
tern[illegible]
Tran[illegible]
Socie[illegible] [illegible]ational
Sociological Association.

HORKHEIMER, M 1936 Autorität und familie Paris Librairie Felix Alcan

Hutchinson, B 1954 Old people in a modern Australian community Melbourne Melbourne University Press

Ingegnieros, S 1958 Aspetti gerontologici Milanesi Milan Commune di Milano

King, G 1955 Policy and practice *In* Old age in the modern world, pp 36–45 Edinburgh E & S Livingstone

König, R 1946 Materialen zur Soziologie der Familie Bern A Francke

Kooy, G A 1957 Changes in the Dutch nuclear family's position and character in the twentieth century (Unpublished paper proposed for International Family Research Seminar)

——— 1960 Social system and the problem of aging Paper given at Seminar on Aging and Mental Health, Fifth International Congress of Gerontology

——— 1960 The rural aging in the Netherlands Paper given at Fifth International Congress of Gerontology

Lefebvre, H 1953 Structures familiales comparées *In* G Friedmann (ed), *Villes et campagnes civilisation urbaine et civilisation rurale en France*, pp 327–33 Paris Librairie Armand Colin

Le Play, P G F 1935 Method and socio

Mogey, J M 1956 Family and neighbourhood two studies in Oxford London Oxford University Press

Myrdal, Alva 1945 Nation and family the Swedish experiment in democratic family and population policy London Routledge & Kegan Paul

Myrdal Alva, and Klein, V 1956 Women's two roles, home and work London Routledge & Kegan Paul

Pagani, A 1958 Causes of institutionalization *In* The need for cross national surveys of old age, pp 53–58 Ann Arbor Division of Gerontology, University of Michigan

Rodnick, D 1948 Postwar Germans, an anthropologist's account New Haven Conn Yale University Press

Sauvy, A 1955 The historical and sociological basis *In* Old age in the modern world, pp 28–32 Edinburgh E & S Livingstone

Schaffner, B 1948 Fatherland a study of authoritarianism in the German family New York Columbia University Press

Schelsky, H 1953 Wandlungen der deutschen Familie in der Gegenwart Dortmund Ardey Verlag

Sheldon, J H 1948 The social medicine of old age report of an inquiry in Wolverhampton London Oxford University Press

——— 1955 The social philosophy of old age *In* Old age in the modern world, pp 15 26 Edinburgh E & S Livingstone

Shenfield, Barbara F 1957 Social policies for old age a review of social provision for old age in Great Britain London Routledge & Kegan Paul

Slater, E , and Woodside M 1951 Patterns of marriage a study of marriage relationships in the urban working classes London Cassell

Swedish Institute of Public Opinion Research 1956 På Äldre Dagar Stockholm The Institute

Tartler, R 1960 The older person in relation to family community and societal factors Paper presented at Seminar on Aging and Mental Health Fifth International Congress of Gerontology

Townsend P 1957 The family life of old people London Routledge & Kegan Paul

Tréanton J R 1959 Adjustment of older people to urban life in France *In* C Tibbitts (ed), Aging and social health in the United States and Europe pp 167 73 Ann Arbor Division of Gerontology University of Michigan

Van Andel, J C and Van Andel Ripke, O 1953 Oud worden in deze tijd Man en vrouw rondom en boven de zestig Met een bijdrage van P J Bouman over het historisch en sociologisch aspect van de problemen van de ouderdom Utrecht Erven J Bijleveld

Wurzbacher G 1951 Leitbilder gegenwärtigen deutschen Familienlebens Dortmund Ardey Verlag

Young M , and Willmott, P 1957 Family and kinship in East London London Routledge & Kegan Paul

IX

Life beyond Family and Work

ROBERT J HAVIGHURST

I General Approaches to the Social Problem of Aging

All the Western societies appear to have followed the same general course in dealing with the social problem of old age, though each society has applied the general solution in a way which is specific and characteristic of that society At first the problem is conceived as an economic problem, and the solution is some sort of pension to alleviate the poverty of many older people

Next, the conception of the problem is broadened to include the matter of comfortable living arrangements for older people This aspect of the problem arose because more and more older people were living apart from their adult children and often had to live in the oldest and poorest dwellings of the community Since the general problem of housing was coming to be considered a social problem, and public financed housing was being built for younger people, it was natural to consider the needs of older people also for public housing Moreover, many older people who could afford to pay for good housing created a demand for living quarters especially adapted to their needs and wishes The problem of housing for older people is not yet met as adequately as the problem of assuring adequate income, but it also is on the path of solution

The third stage in recognition and solution of the social problem of old age is to conceive it as a psychological problem for the individual older person who needs ego-supporting relationships and activities to help him meet the attacks on his ego which arise from (a) the lessening of his physical

[1] The author wishes to acknowledge with many thanks the friendly assistance of the following persons in the preparation of this chapter Dr Ali Berggren and Miss Maud Helling Royal Social Welfare Board, Stockholm, Lars Ögren, Swedish Institute of Public Opinion Research, and Dr Bengt Rundblad, Department of Sociology, University of Uppsala *Sweden*, Dr Henning Friis, adviser to the Ministry of Social Affairs, and Rudolf Conrad, director of social welfare, Copenhagen *Denmark*, Dr Johannes Roth, secretary, Stiftung fur das Alter Zurich *Switzerland*, Dr R. J van Zonneveld, National Health Research Council, R Wentholt, Ministry of Social Affairs, C W van Dam secretary Dutch Federation for the Care of the Aged, and Mr Streuer director of [illegible]

[illegible] Institute of the University, Hamburg *Germany* and Allen Sanderson director Calouste Gulbenkian Foundation, F Le Gros Clark, Nuffield Foundation, Peter Townsend, London School of Economics and Political Science, Marjorie Bucke National Old P[illegible]

vigor and attractiveness, (*b*) the lessening of his mental efficiency, (*c*) the lessening of his satisfactions gained from his work, and (*d*) the loss of spouse or relatives or friends

This third stage is generally reached in a society only after the first two have been worked through When the first two stages have progressed to the point where it is clear that there still remains a social problem of old age, people are ready to recognize and attack the third aspect of the problem—that of ego support for older people They then recognize that older people have a need to be needed—a need to have a respected place in the eyes of others and to be doing something which is interesting and significant in one's own eyes

Only a few societies have reached this third stage of social gerontology, though there are far seeing, sensitive individuals in all societies who have discerned the need It has been defined by the leading social gerontologists in Sweden, the country which has the keenest sense of society's responsibility for the individual and of the individual's responsibility for society In a talk at a United Nations conference in 1955, Helge Dahlstrom, director of the Swedish Social Welfare Office, put in one paragraph these three stages or tasks of social gerontology

> Our basis for the measures for the aged is *the conception that old people should be given the possibility to live a free and independent* life to the same extent and with the same social amenities as the other age groups in society To realize these aims it is at first necessary that *old people should have financial security* Furthermore and in the second place the [illegible]
>
> own homes as long as possible There also are to be measures which will help to make their lives pleasant and which break through the isolation *from the outside world* which so very easily becomes the lot of old people

A few pioneering attempts to solve the social problem of old age at this third level may be seen in several modern Western societies These pioneer projects vary a great deal from one society to another partly because they are experimental in nature and partly because they depend so much on the "national character" of a society While Western societies have much in common in their economic and political evolution, they differ among themselves in psychosociological characteristics and, consequently, tend to differ in the ways they meet the psychological aspects of the social problem of aging Thus, in comparing Western societies, we shall see rather marked differences in the ways they attempt to meet the problem of ego support, although the differences are minor when one compares Western societies in general with other large groups of societies

A Social Roles of Adult Life

To make a clear, comparative study of the ways various countries attack this third aspect of the problems of aging we have adopted the concept of *social role* as our major intellectual instrument. We shall compare several social roles of older people in the various Western societies

The social life of a person can be described in terms of his performance of a number of social roles A social role is a pattern of behavior which is taught by a social group and is expected by the group of those of its members who are in a certain social position Thus a man may have the roles of worker, husband, father, citizen, etc while a woman may have the roles of wife, mother, citizen worker, etc When filling a particular role a person behaves according to certain social expectations and is judged by the society in accordance with his fulfilment of these expectations

For example, it is sometimes said of a man that "he makes a good father" and of another man that "he makes a poor husband" This means that the first man is living up to the expectations of his society as he fulfils the role of father while the

second man does not fill the role of husband adequately in the eyes of the people around him in his society

The social life of an adult can be fairly well depicted by a description of his behavior in the following roles worker spouse parent homemaker club or association member friend citizen church member user of leisure time and student [illegible]

[illegible]self to be a competent and successful person This latter fact is important for our argument A member of a society takes into himself the social expectations and expects of himself the kinds of behavior that the society around him expects Sometimes he sets for himself a lower or a higher standard than that of the society around him but his expectation of himself is always clearly and visibly related to the social expectations which impinge upon him

It should be possible with this concept to describe what a society expects of people as they grow older and also to judge how well they meet these social expectations. It should also be possible to compare the lives of older people in various societies in this way

For this particular chapter we shall exclude from consideration the roles of worker and of spouse parent and homemaker These are dealt with in the chapters treating work and family relationships We shall consider then the following roles club or association member friend citizen church member user of leisure time and student.

There is an inevitable decrease in competence and in satisfaction with the worker role as a person grows older Fortunately the family roles remain important sources of ego support especially for women But especially in urban societies older people are thrown more and more upon the roles beyond work and family for satisfaction If they fill these roles well they are likely to be happy and well adjusted people

From the early sixties to the late seventies the satisfaction and happiness of most people depend on the competence with which they fill several of these roles After this, as they enter the final period of life their physical energy and/or their mental acuity fade enough to cause them to disengage themselves from the active roles of life to find a "rocking chair," and to survey the world from its vantage point. Very few can happily find a rocking chair in their sixties

In this chapter we shall consider each role in two aspects what society expects of older people in this role and how well older people actually fill the role. As far as possible we shall do this for each of the societies under consideration

Actually we shall have to be content with only preliminary and tentative descriptions *in* most cases because there are not many scientific studies available on these topics Consequently, we shall have to rely upon the *impressions* of acute observers in the various societies This chapter therefore must be regarded as tentative in its conclusions and open to considerable correction by more careful studies which may be made in the future

It will also be noticed that we have included in our list of social roles one—or maybe two—which has little importance for a great many people The least important from this point of view is that of student While this is an important role for children and young people it is not generally regarded as important for older people Furthermore the role of user of leisure time is not a clearly defined one as far as social expectations go in most modern social groups But it is included here because of its potential importance in the Western societies if present social trends continue to develop

B Roles of the Elderly Change in a Changing Society

Between 100 and 150 years ago the modern industrial countries emerged from a

stage in which they were all pretty much alike in respect to the life of older people They were predominantly rural countries, though England in particular already showed the beginnings of urbanism In those rural societies the functions and the status of older people were quite similar and centered around the family and its economic life There were economic and family roles which were *functional*—that is, which were useful to the society and meaningful to the individual The old person was always useful as long as he could be active in the work of the family As a grandparent, he had a useful set of functions He could respect himself and be respected by others The roles outside work and the family had relatively little significance and involved relatively little time in the rural areas though they generally had more significance in the growing cities

As a *citizen* the older person continued the interests and activities of his middle age These were negligible for women who did not have suffrage and who were not expected to be active in civic matters For men the civic activities were limited to a few property owners professional workers, and a small number of leaders of labor Many ordinary men did not possess the right to vote

As a *club or association member* there was little opportunity for the common man or woman Such people did not belong to associations There were no associations of older people as such But the few middle- and upper class men who belonged to clubs or to learned societies retained their memberships as they grew older and probably gained a good deal of satisfaction from them

As a *church member* the individual had the consolations of the church which were important for older people But there were few or no active roles to be performed by the ordinary layman, regardless of his age

The role of *friend* was a satisfying one for those who had friends outside the family They could get together for visits—the women in their homes and the men in neighborhood meeting places, such as the tavern, the general store, and the local park in warm weather There were however, no practice of finding and making new friends and no arrangements for promoting the formation of new friendships

There was no concept of *leisure time activity* as a social role Men did not retire from work until they were forced to do so by failing powers, and, consequently, they did not have abundant time and energy for leisure activity Women did their traditional handwork if they could sew and use their fingers People did not deliberately seek *new* leisure activities as they grew older

The notion of the older person as a *student* was quite foreign There was no idea of studying to prepare for something new in one's later years Only those who had been students all their lives continued to be students in their old age

OLD AGE 100 YEARS AGO

To summarize the facts about older people 100 years ago we find that their position in society was much the same in all of western Europe They were expected to work as long as possible and to continue to be whatever they had been in middle age When this was no longer possible they were supposed to live quiet, secluded lives. They were not a recognizable social group or a recognizable social problem If there were tragedies as there certainly were, they were quiet lonely tragedies

CHANGING SOCIAL CONDITIONS

As the industrial revolution gathered speed and the cities grew at the expense of the rural villages and open countryside a number of factors conspired to make major changes in the lives of older people In the economic sphere the size of the group who had their own independent business, land profession or trade decreased, and the size of the group increased who were employed by industry, commercial organizations, and the state

These wage-workers lost their jobs as they grew older and they could not at first retain any power over the matter of whether they should work or not. Then as the workers organized and grew more powerful they were able to trade their rights to a job for rights to a pension which gained them a measure of economic security but left them with no active economic role.

In the urban family the older people lost much of their economic function while the normal tensions between them and their adult children increased owing to unsatisfactory living conditions and the growing uselessness of the older generation in the family. Therefore older people preferred to live in their own quarters apart from their grown children if this was possible. And the number of older people living alone without a spouse or other relative increased in the urban areas.

At the same time the proportion of older people increased in the population growing from 2 or 3 per cent to 8 or 10 per cent if the proportion 65 and over is considered. Within this group the ratio of the sexes changed somewhat with an increasing proportion of women and a much increased proportion of widows.

These changes were most striking in the industrialized areas. In the rural areas the social changes were much slower and today the roles of older people in rural communities are still much like they were 100 years ago.

C Social Policy for Old Age

In the modern urban industrial society decisions are made by the society as a political and a social entity which affect the lives of old people. A modern society has a *social policy for old age*. This was not true of the earlier society with its rural and pre-industrial characteristics. *There* was no need for a policy for old age in such a society because there was no problem of old age. *There* were economic functions for all able bodied people and there were traditional roles which fitted the economic functions. Old people were not plentiful and they were seldom "in the way." If they became ill or infirm they were cared for as a duty by the family or, in special cases, by charitable institutions. There was no stated social policy and no code concerning the lives of older people.

The modern society is more conscious of its older people and of their presence as a factor in the society's well being. They may constitute a positive or a negative factor. Economically their presence is both favorable and unfavorable as the economists are discovering. *In the family* roles their functions are both positive and negative.

Society adopts a set of procedures for dealing with the economic and family roles of older people so as to increase the positive factors and reduce the negative ones. This *set of procedures is* the result of a social policy.

Generally speaking there are two alternative social policies for old age. They are the opposite ends of a continuum and societies range themselves between the two ends.

The one *extreme might* be called the policy of *autonomy*. In this case the older person is expected to preserve his independence, freedom of action and initiative as nearly as possible as it was at his peak of autonomy which comes in the middle years in modern societies. He is expected to exercise a maximum of choice about his life. This policy must operate in the light of the fact that people generally become less able to exercise independence as they move into old age. They have lower efficiency as workers, their health is impaired, and they may lose economic independence. The current social policy is *to supplement their resources* in such a way as to preserve and enhance their autonomy. This policy encourages individual saving, homeownership, employment as long as possible, and active leisure pursuits such as gardening and travel. It seeks to strengthen the institutions which protect autonomy—the local community, small pri

vate business, private pension systems, the single family home It argues that a great good is associated with the need to *look after one's self* in one's old age, even though it may be difficult to do so This policy would use specialists in the study and treatment of older people in such a way as to assist personal initiative on the part of older people

At the other extreme is the policy of *passivity for the individual* Here it is assumed that the aged individual cannot care for himself in his later years and cannot guarantee his old age security by planning and saving in his middle age The modern society is too complex for him to meet autonomously The solution is for the state to provide financial security through a general old age pension and to provide other forms of assistance to meet his non-financial needs This policy would build up a staff of specialists in the care of older people—doctors nurses, social workers, housekeepers, club leaders, and counselors —whose function it is to make old age as comfortable and enjoyable as possible for people

To most readers this policy of state aid with individual passivity would have little appeal, while the policy of autonomy, with supplemental state assistance on a minimum basis, would have a considerable appeal But the policy of autonomy can rightly be criticized as unrealistic, if it is carried very far, in a modern industrial society In such a society the average person has little experience of autonomy in the economic sense He has little or no control over his income He saves little or no money unless he is required to do so by a compulsory insurance program His leisure activities are mainly passive and are determined for him by others who control the mass entertainment media Consequently, such a person can hardly be expected to become suddenly autonomous at the age of 65

In fact, the modern industrial societies are all working out a policy somewhere between the two extremes and generally toward the autonomy pole If a considerable degree of autonomy in old age is desirable, then probably the roles of association member, friend, citizen, and user of leisure time deserve special attention For through these roles the older person is more likely to achieve or preserve autonomy than through the work role, where most older people have lost control of their destiny The family roles, however, remain as areas for the exercise of autonomy and indeed, almost as battlegrounds in the struggle for autonomy on the part of older people In his family life the older person strives to maintain old functions or to discover new ones which will give him satisfaction, and he does this with a minimum of assistance or involvement on the part of other institutions, such as the state

II Comparing Old Age in Modern Societies

The purpose of the remainder of this chapter is to compare the experience of older people in various Western nations with respect to the roles of living outside work and family relations This will be done in two steps The situation of older people will be described in each country with special reference to the roles mentioned above In the concluding section the roles will be taken up one by one, and the various countries will be compared with respect to each role

A Sweden

The Swedish old age population has for over 50 years been proportionally one of the largest in Europe At present approximately 11 per cent of the population are over 65 Although one of the later northern European countries to become industrialized (after 1870), the population conditions in Sweden have been similar to that of England and France

Relatively early Sweden adopted a system of social security for old people, which is one of the more complete and complex in Europe It grants a flat old age pension

at age 67 to everyone, regardless of his means, and the amount is relatively liberal. There is a current program for increasing the old age pension which, relative to the cost of living, will make it the highest in the world.

Sweden has also moved far ahead of most other countries in providing adequate housing for older people, especially people of small means. The housing policy has the following principles:

1. A person should have a maximum of autonomy in choosing and caring for his own home.
2. Most older people want to live in the neighborhood to which they have grown accustomed. The home help and "meals on wheels" services help them to live in their own home quasi-independent as long as possible.
3. In the state program of public financed housing old people should get their fair share.
4. For those with limited financial means there is a housing subsidy.

Thus Sweden has made relatively great progress in meeting the material needs of older people. The need for autonomy, or ego support, is also widely recognized and often spoken of by social welfare officials. In the municipal Old People's Home in Stockholm, for instance, every resident has his name and apartment or room number on a wall directory at the entrance, just as though he were a tenant in a first class apartment house.

The state appears as an active partner in almost all schemes to improve the conditions of life for older people. Yet the state does not dominate people in Sweden. It acts as an enabling agent to put into effect the social will, which is friendly toward old people.

The society is hospitable to the concept of social and civic activity for older people who are specifically encouraged to be active in clubs and associations, to join study circles, to travel, to take an active interest in the affairs of the day, and to develop hobbies.

At the level of ego support, or autonomy, Sweden is working experimentally in a number of ways. But here the state must by its very nature go slowly, since its purpose is to encourage personal autonomy rather than a passive acceptance of society's favors.

Sweden illustrates the fact that there is a certain tension—not to say conflict—between a policy of promoting the material welfare of older people through pensions and public housing and a policy of promoting autonomy. The Swedes are aware of this and attempt in their state welfare programs to favor a policy of autonomy.

In the following sections the factual material comes mainly from an unpublished report entitled "På Äldre Dagar" of an interview study made in June, 1956, of a national sample of people over 56 by the Swedish Institute for Public Opinion Research. The material concerning expectations about older people comes from interviews held by the writer with social welfare workers and social scientists in Sweden.

ROLE OF CLUB OR ASSOCIATION MEMBER

The Swedes think of Sweden as a land of democratic associations. They expect persons to belong to associations, not only to trade unions or professional associations, but also to any of a variety of others which are organized for purposes of social welfare, temperance, education, etc.

From a study of participation in associations, it appears that about 25 per cent of the population aged 57 and over belong to associations other than a trade union or political organization. There is not much difference in extent of membership in ordinary associations between those aged 18–56 and those aged 57 and over (Table 1).

There is a falling-off in active participation in associations as people grow older. Thus, as shown in Table 2, about 28 per cent of those aged 57–66 attend association meetings as often as once a month, while this proportion drops to 21 per cent for those over 67.

There is a considerable verbal desire for more participation in organizations as shown in Table 3.

vate business, private pension systems, the single family home It argues that a great good is associated with the need to *look after one's self* in one's old age, even though it may be difficult to do so This policy would use specialists in the study and treatment of older people in such a way as to assist personal initiative on the part of older people

At the other extreme is the policy of *passivity for the individual* Here it is assumed that the aged individual cannot care for himself in his later years and cannot guarantee his old age security by planning and saving in his middle age The modern society is too complex for him to meet autonomously The solution is for the state to provide financial security through a general old age pension and to provide other forms of assistance to meet his non-financial needs This policy would build up a staff of specialists in the care of older people—doctors, nurses, social workers, housekeepers, club leaders, and counselors—whose function it is to make old age as comfortable and enjoyable as possible for people

To most readers this policy of state aid with individual passivity would have little appeal, while the policy of autonomy, with supplemental state assistance on a minimum basis, would have a considerable appeal But the policy of autonomy can rightly be criticized as unrealistic, if it is carried very far, in a modern industrial society In such a society the average person has little experience of autonomy in the economic sense He has little or no control over his income He saves little or no money unless he is required to do so by a compulsory insurance program His leisure activities are mainly passive and are determined for him by others who control the mass entertainment media Consequently, such a person can hardly be expected to become suddenly autonomous at the age of 65

In fact, the modern industrial societies are all working out a policy somewhere between the two extremes and generally toward the autonomy pole If a considerable degree of autonomy in old age is desirable, then probably the roles of association member, friend, citizen, and user of leisure time deserve special attention For through these roles the older person is more likely to achieve or preserve autonomy than through the work role, where most older people have lost control of their destiny The family roles, however, remain as areas for the exercise of autonomy and indeed, almost as battlegrounds in the struggle for autonomy on the part of older people In his family life the older person strives to maintain old functions or to discover new ones which will give him satisfaction, and he does this with a minimum of assistance or involvement on the part of other institutions, such as the state

II Comparing Old Age in Modern Societies

The purpose of the remainder of this chapter is to compare the experience of older people in various Western nations with respect to the roles of living outside work and family relations This will be done in two steps The situation of older people will be described in each country, with special reference to the roles mentioned above In the concluding section the roles will be taken up, one by one, and the various countries will be compared with respect to each role

A Sweden

The Swedish old age population has for over 50 years been proportionally one of the largest in Europe At present approximately 11 per cent of the population are over 65 Although one of the later northern European countries to become industrialized (after 1870), the population conditions in Sweden have been similar to that of England and France

Relatively early Sweden adopted a system of social security for old people, which is one of the more complete and complex in Europe It grants a flat old age pension

at age 67 to everyone regardless of his means and the amount is relatively liberal There is a current program for increasing the old age pension which relative to the cost of living will make it the highest in the world

Sweden has also moved far ahead of most other countries in providing adequate housing for older people especially people of small means The housing policy has the following principles

1 A person should have a maximum of autonomy in choosing and caring for his own home

2 Most older people want to live in the neighborhood to which they have grown accustomed. The "home help and meals-on wheels" an ... h

Thus Sweden has made relatively great progress in meeting the material needs of older people The need for autonomy or ego support is also widely recognized and often spoken of by social welfare officials In the municipal Old People s Home in Stockholm for instance every resident has his name and apartment or room number on a wall directory at the entrance just as though he were a tenant in a first class apartment house

The state appears as an active partner in almost all schemes to improve the conditions of life for older people Yet the state does not dominate people in Sweden It acts as an enabling agent to put into effect the social will which is friendly toward old people

The society is hospitable to the concept of social and civic activity for older people who are specifically encouraged to be active in clubs and associations to join study circles to travel to take an active interest in the affairs of the day and to develop hobbies.

At the level of ego support or autonomy Sweden is working experimentally in a number of ways But here the state must by its very nature go slowly, since its purpose is to encourage personal autonomy rather than a passive acceptance of society s favors

Sweden illustrates the fact that there is a certain tension—not to say conflict—between a policy of promoting the material welfare of older people through pensions and public housing and a policy of promoting autonomy The Swedes are aware of this and attempt in their state welfare programs to favor a policy of autonomy

In the following sections the factual material comes mainly from an unpublished report entitled ' På Äldre Dagar of an interview study made in June 1956 of a national sample of people over 56 by the Swedish Institute for Public Opinion Research The material concerning expectations about older people comes from interviews held by the writer with social welfare workers and social scientists in Sweden

ROLE OF CLUB OR ASSOCIATION MEMBER

The Swedes think of Sweden as a land of *democratic associations* They expect persons to belong to associations not only to trade unions or professional associations but also to any of a variety of others which are organized for purposes of social welfare temperance education etc.

From a study of participation in associations it appears that about 25 per cent of the population aged 57 and over belong to associations other than a trade union or political organization There is not much difference in extent of membership in ordinary associations between those aged 18–56 and those aged 57 and over (Table 1)

There is a falling-off in active participation in associations as people grow older Thus as shown in Table 2 about 28 per cent of those aged 57–66 attend association meetings as often as once a month while this proportion *drops to 21* per cent for those over 67

There is a considerable verbal desire for more participation in organizations as shown in Table 3

Associations in Sweden seem to be more business-like and more "earnest" than in the United States Associations for the pur pose of sociability are not common, but the Old Age Pensioners Association seems to serve this purpose to some extent

TABLE 1*

MEMBERSHIP IN SWEDISH ORGANIZATIONS

(Excluding Trade Unions and Professional Associations)

(Per Cent)

Organization	Age	
	18 56	57 and Over
Political		
Farmers party	4	4
Liberal party	2	2
Social Democratic party	9	6
Conservative party	3	4
No political	82	84
Christian (free church)	7	9
Temperance	5	5
Sports	13	1
Red Cross†	9	14

* Source Swedish Institute for Public Opinion På Äldre Dagar (unpublished report 1956)

† The Swedish Red Cross has a relatively active program in local communities

TABLE 2*

ATTENDANCE AT SWEDISH ASSOCIATION MEETINGS

(Excluding Trade Unions and Professional Associations)

(Per Cent)

Attendance	Age	
	57 66	67 and Over
At least once a week	5	4
At least once a month	23	17
At least once a quarter	14	8
At least once a half year	6	5
At least once a year	5	3
Less than once a year	40	55
No answer	7	8
No of respondents	(349)	(285)

* Source Swedish Institute for Public Opinion På Äldre Dagar (unpublished report 1956)

It seems probable that Sweden has a wider participation of working class people in mixed age associations than does the United States This is partly because of the popularity of temperance and Red Cross societies, which appeal to people of lower middle and working class status, and partly to the fact that the "free churches are treated as associations in Sweden, since everybody is nominally a member of the state church, and the "free churches" are relatively small religious societies (Meth odists, Baptists, Jehovah's Witnesses, Sal vation Army, etc) with voluntary mem bership

TABLE 3*

DESIRE FOR MORE PARTICIPATION IN ORGANIZATIONS SWEDEN

(Would You Like To Be a Member of Any of the Following Organizations in Case You Are Not Now a Member?)

(Per Cent)

Organization	Total Sample Aged 57 and Over Say ng Yes
Labor union or profes sional	9
Christian (free church)	9
Red Cross	8
Temperance	7
Housewives'	5
Political	4
Sports	1
Other	2

* Source Swedish Institute for Public Opinion På Äldre Dagar (unpublished report 1956)

The Swedish Red Cross is a popular as sociation, with greater membership among people over 57 than under this age Ap parently the Red Cross has somewhat greater citizen participation in Sweden than it does in other countries It has taken a special interest in problems of older peo ple and has been instrumental in recruiting and training home help assistants and in providing "meals on wheels" for older peo ple in many communities

The "old people's club" movement seems to be just getting started in Sweden In

1957 there were fourteen old age clubs in the homes for old age pensioners in Stockholm. There was also a new chess club for older people Probably, clubs of this type are just beginning to grow rapidly

The Old Age Pensioners Association is a very active reality and provides a type of old people s club activity It has a dues paying membership of at least 105 000 of a total of 700 000 pensioners and publishes a good monthly magazine While people of all social positions belong to the association the leadership is drawn largely from the Social Democratic party and the membership probably has a relatively high working-class proportion The association took an official position on the recent national referendum on old age security which agreed with that of the Social Democratic party but active Social Democrats pointed out that many of the individual members of the association would vote for other positions In any case the political position of the national organization seems to leave the social and other activities of the local associations unaffected On the local level the Old Age Pensioners Association seems to be mainly a social group with some common welfare functions For instance in the city of Uppsala (80 000) the association holds monthly meetings in the People s House with an attendance of about 1000 There is a lecture, or movie, or some such feature with a mixed educational and entertainment value and then the people drink coffee and have a good time The women of this association have a number of sewing groups which meet in private homes or elsewhere in local neighborhoods Once a year there is a fair for money raising purposes The officers of this association tend to be persons formerly active in Social Democratic circles although Uppsala is a university town with many middle-class people

There is another old age association composed of persons who feel that the Old Age Pensioners Association is too close to the Social Democratic party

ROLE OF FRIEND OR INFORMAL GROUP MEMBER

The Swedes have a saying 'Heaven in this world is to be alone when I want it, Hell is to be alone when I don t want it" Informal friendship relations in Sweden are regarded by older people as rather difficult to establish The Swedes have an outer appearance of reserve which makes it difficult for them to make casual friendships.

Furthermore, there is a considerable "social distance" in Sweden among people of different social classes This is symbolized [illegible] gh

[illegible]

and is addressed in the third person "What does *Doctor* want to eat for dinner? ' A person without a title is simply called '*Herr*" and thus is constantly reminded of the social distance between him and other people This serves to maintain distance among members of the different social classes in spite of an ideology of political democracy

The old people s associations whether conducted by the Old Age Pensioners Association by social workers under the auspices of the local social welfare office, or by churches have more the function of promoting informal social relations than of acting as formal associations with programs and projects As such these organizations appear to fill an important function in the lives of Swedish older people The social welfare boards are making a conscious attempt to encourage informal social relations in the pensioners' apartments by designing them with lounges at accessible places which seem to *invite* people to come out of their private apartments and to associate with others

Swedes of the middle class do a good deal of touring especially older people There are a number of summer tours arranged by travel agencies and by individuals which take Swedes all over Europe For example, a hotel in Merano, Italy, receives several groups each season for pe

riods of 4 or 5 days the people are mainly elderly women who come in pairs or small groups of friends

Informal meeting places for older people are found in Swedish towns and cities—coffeehouses for the men who can afford it parks and reading rooms for all kinds of people There are also several Swedish spas (Medevi, Loka Ramlosa) which are much frequented by older middle and upper class people Then too certain towns are popular with middle and upper class people as good places to live in retirement This is true of Uppsala and Lund pleasant university cities to which people often go to live in retirement

potential political force which has the leaders of all parties interested No doubt a considerable block of votes could be influenced by the organized older people in their own interest Consequently, all parties tend to agree on political questions affecting older people directly, such as the current proposal to increase the basic old age pension

There is not much prestige for older people in politics as such the leadership in political organizations generally going to young and middle-aged people A number of older people who were political leaders now get satisfaction from leadership in the Old Age Pensioners Association

TABLE 4*

SWEDISH PEOPLE EXPRESSING STRONG OR STRONGEST INTEREST IN WORSHIP AND RELIGION

(On a Five Point Scale of Interest)

	Age						
	1[illegible]–18	19–28	29–36	3[illegible]–55	56–61	62–70	71 and Over
Percentage of people expressing interest	6	7	6	15	25	32	45

* Source Swedish Institute for Public Opinion [illegible], unpublished report 1956

ROLE OF CITIZEN

Older people are expected to be active citizens and their behavior indicates that they retain their civic interests Answering the question whether they voted in the last election people aged 57–66 indicated a proportion of 91 per cent voting which was about the same as for those of middle age There was a slight falling off to about 85 per cent voting when over the age of 67

As Table 1 indicated older people have a slight tendency to vote more conservatively than middle aged or younger people But this may reflect a decrease of conservative political strength in recent decades rather than an actual change in the political convictions of the present older people The Old Age Pensioners Association is a

ROLE OF CHURCH MEMBER

People are generally expected to attend church more regularly and to be more interested in religion as they grow older The evidence of Table 4 indicates that this actually takes place to a considerable extent with substantial increase of interest in religion and worship after the age of 56 This table does not tell whether the people have individually become more interested in religion or whether the present older generation reflects a greater interest in religion on the part of younger and middle aged people a generation ago

Individual older people do not get much chance for leadership in church organizations However, the churches give more opportunity to older people for leadership

than do other organizations, as can be seen in the fact that 4 per cent of church members over 57 were officers, compared with 2 per cent of Red Cross members over 57, 1 per cent in political organizations, and 1 per cent in the Red Cross

Much of the general activity of the churches is directed toward older people (sewing circles, visiting done by pastors etc.) Many of the free churches, also, have built old age homes for their older members Among the people who were active as "visitors" in the state church 47 per cent were over 57 in 1955 while 39 per cent of the free-church visitors were also over 57 Nevertheless the extent of church activity and interest in social problems of old age appears to be less than in the Netherlands and the United States

ROLE OF USER OF LEISURE TIME

It is a generally accepted proposition in Sweden that healthy old people (like people of other ages) should be active and need active kinds of recreation The tennis playing of the aged King Gustav was a symbol of this attitude The term hobby is used respectfully in Sweden whereas it has a slightly scornful connotation in some other countries

The social welfare boards have 'hobby rooms' in their old people's homes with occupational therapists to teach people weaving and other arts The tradition of home arts and crafts is supported officially by the social welfare boards In the new pensioners' apartments there is talk of establishing hobby rooms and the leaders of the People's House organization speak of furnishing such rooms in their buildings

As will be seen in Table 5 older people actually tend to spend more time in passive *things* such as reading and radio-listening although an impressive 40 per cent of the people aged 68–73 say that they work more on hobbies than they did when younger When asked *what* the things were for which they had insufficient possibilities the older people in the public opinion study expressed dissatisfaction with possibilities for travel (18 per cent) and going to movies (12 per cent)

According to Table 6, old people retain or increase their interests in newspaper-reading, literature, gardening, travel, and music up to the age of 70 In the more demanding intellectual operations of playing chess, solving problems, etc, they lose interest after 60

One very popular leisure activity in Sweden is the football pool a form of government administered lottery, and between a third and half of the people aged 57–66 participate once a month or more (Table 7) The answers to the question, "If you should win 75,000 kronor, what would you do with the money?' are given in Table 8

TABLE 5*

INCREASED ACTIVITIES OF RETIRED SWEDISH PEOPLE

(Since You Have Retired What Have You Done More Of?)
(Per Cent)

Activity	Age			
	Male		Female	
	68 73	74 and Over	68 73	74 and Over
Listen more to radio	52	61	67	66
Read more books	43	52	27	24
Work more on hobbies	42	23	40	21
Go to church more	5	10	47	10

* Source Swedish Institute for Public Opinion on "På Ålre Dagar" (unpublished report 1956)

ROLE OF STUDENT

Adult education has been popular in Sweden since the development of folk high schools in the last century Recently, there has been a new wave of interest, this time in a small "study-circle" type of educational activity, quite different from the earlier formal lecture type of educational program The state will provide a partial

subsidy for any study circle with five or more members There were 37,920 study circles in 1952–53 and 48,096 in 1954–55 Assuming an average membership of ten to a study circle, this gives 480,000, or 10 per cent of the population age 20 and over Of the study circles, 20,000 are sponsored by the Workers Adult Education Association, an independent organization affiliated with the Social Democratic party Thus they reach many working class people Of persons 57 years old and over, 2 per cent belong to study circles, with interests mainly in "cultural" subjects, such as literature, and in current social problems The vocational training function of the

TABLE 6*

SWEDISH PEOPLE EXPRESSING A 'STRONG' OR 'STRONGEST' INTEREST IN CERTAIN ACTIVITIES AT VARIOUS AGES

(Per Cent)

Age	Activity					
	News	Reading Good Literature	Listening to Music	Gardening	Travel or Reading about Travel	Solving Intellectual Problems Chess Etc
11 14	19	8	41	10	31	18
15 18	27	11	47	6	34	13
19 23	31	14	42	14	36	18
24 28	44	19	40	14	35	16
29 36	43	18	35	24	35	11
37–45	44	20	36	26	36	16
46 55	63	22	53	45	45	19
56–61	56	18	33	36	21	16
62 70	56	15	33	34	25	9
71 and over	43	9	28	22	9	8

* Source Swedish Institute for Public Opinion På Äldre Dagar (unpublished report 1956)

TABLE 7*

PARTICIPATION IN THE FOOTBALL POOL SWEDEN

("Do You Buy Pool Tickets? If So How Often?")

(Per Cent)

Frequency	Age	
	57 66	67 and Over
Every week	28	12
Twice a month	5	5
Once a month or less	16	9
Never	51	72

* Source Swedish Institute for Public Opinion På Äldre Dagar (unpublished report 1956)

TABLE 8*

PROBABLE USE OF FOOTBALL-POOL WINNINGS SWEDEN

("If You Should Win 75 000 Kronor What Would You Do with the Money?")

(Per Cent)

Probable Use	Age	
	57 66	67 and Over
Travel	10	4
Buy a home	25	18
Live in better style	10	17
Improve living quarters	13	11
Give it to children or relatives	11	29
Give part or all to charity	3	11
Save it	22	11
Invest in a business	2	0
Pay some debts	5	1

* Source Swedish Institute for Public Opinion På Äldre Dagar (unpublished report 1956)

study circle for younger people does not have much significance for older people as can be seen in Table 9

Generally speaking, adult education even in its modern and more attractive form has no great appeal to older people in Sweden. But there is discussion now, of developing study circles and discussion groups dealing with preparation for retirement This will probably be given a trial in Sweden Also some study circles for older people are now being started which are more social and less intellectual in program than the usual study circle The sponsor of one of these says that it should be called a satisfaction circle rather than a "study circle"

B Denmark

The Danish old age population is similar in proportion to that of Switzerland and Germany It has been growing more slowly than that of Sweden France and Great Britain At present approximately 10 per cent are over 65

The Danish system of social security is one of the more adequate ones All Danish citizens of 67 years or more (exclusive of civil service pensioners) are entitled to a national pension of a fixed amount with a supplement where need can be proved

Public housing for older people has been provided by many of the towns of Denmark as well as by Copenhagen on a scheme whereby the central government pays half of the cost and the local community pays half There are about 370 000 old age pensioners in Denmark and about 30 000 of them live either in public housing 'pensioners flats or in municipal old people s homes

Recently there has been some criticism of the policy of *segregating* old age pensioners in special *apartment* buildings and consequently the Danish government has adopted a plan for paying rent subsidies to old age pensioners who live in non profit housing projects, no matter where they are located In general, it can be said that the state has made liberal provision for income and housing for older persons who need help in Denmark

With respect to ego support, there is relatively little going on in Denmark, though people are beginning to talk about it There are four agencies or groups that have expressed an interest in and claim to be doing something about helping older people to find more meaning in life These four are the church, the municipal social welfare agencies, private welfare agencies, and the old age pensioners' associations It is too early to say which of these organizations will find ways of working effectively on behalf of older people

TABLE 9*

REASONS GIVEN FOR STUDYING BY OLDER AND YOUNGER SWEDISH PEOPLE
(Per Cent)

Reason	Age	
	18-56	57 and Over
To improve vocational performance	21	9
To prepare for an examination	1	0
For pleasure or because of personal interest	56	69
Other reasons	10	3
Cannot answer	9	20

* Source Swedish Institute for Public Opinion "Pa Tidens Dagar" unpublished report 1956

ROLE OF CLUB OR ASSOCIATION MEMBER

Like the Swedes the Danes do not have *many* organizations for purely social purposes They have associations for *serious* purposes—mainly economic and political The Danes do not have *such* strong temperance societies free *church* societies and Red C[illegible] conseq[illegible] associa[illegible] Dane who is an a[illegible] [illegible]ves However a to[illegible] exc[illegible] ter[illegible] trade union

In recent years there has been some growth of old people s clubs Two old age

pensioners' associations have been formed A voluntary organization known as the Society for the Care of Lonely Old People (Ensomme Gamles Vaern) was founded in 1952, and the Lutheran Welfare Society has started a movement in the Danish state church to organize work on behalf of old people

To date the activities of these organizations have remained on a highly informal level A typical church program consists of visits by the pastor and members of a group of visitors to older members of the parish, with coffee hours in the home of the pastor for the older people Much of the success of the program depends on the pastor's wife

TABLE 10*

ANSWERS TO QUESTIONS BY SAMPLE OF 1200 DANISH PERSONS 60 AND OVER BY PLACE OF RESIDENCE

(Per Cent)

Like To Spend Time with —	Copenhagen	Provincial Towns	Rural and Semi rural
Other old people	28	32	48
Young people	22	12	7
Both groups	50	56	45

* Source Danish Gallup Institute 1951

The Society for the Care of Lonely Old People is privately supported and works mainly in Copenhagen It has ten "winter rooms" in Copenhagen, which are social centers under the direction of volunteer middle class women Some 4000 people come to these centers for entertainment and for coffee and pastry, for which they pay a small fee During the four summer months the society operates a rural colony which accommodates 440 people for two week vacation periods In the course of the summer there are two gatherings in Tivoli (the famous amusement park in the center of Copenhagen) each for 1000 old people, and there is a Midsummer Eve festival

A poll by the Danish Gallup Institute in 1951 was taken on a sample of 1200 men (65 and over) and women (60 and over) The question was asked, "Whom do you like best to spend your time with?" The answers to this question are given in Table 10 These figures may indicate that the rural older people have a more stable and "normal" social life They have their friends of their own age as well as their families of mixed ages The older people in the city may be striving harder to keep "young and active"

ROLE OF FRIEND OR INFORMAL SOCIAL GROUP MEMBER

In Denmark most social activity among friends takes place in the home rather than in clubs or public places Consequently, those older persons who live with their families tend to see their friends in their homes On the other hand, those who live alone, in pensioners' flats and other similar lodgings, generally have relatively little informal social activity with friends

THE ROLE OF CITIZEN

The Dane is expected to retain his interest in civic affairs as he grows older To help him in this, a number of old age pensioners' organizations have recently sprung up Two of them are the Folkepensionist Foreningen, founded in 1939, and the Folke og Invalidepensionist Foreningen, founded in 1945

These organizations have potential political power and they also provide a certain amount of informal social relationship through serving coffee after their meetings Leaders of these associations are older people

ROLE OF CHURCH MEMBER

The Danes generally take their state church for granted, with the older people more loyal in attending and taking communion Older people have a good deal of prestige in the churches and tend to retain their position on the church councils

An attempt was made, a few years ago by the church to organize and hold religious services in the old age pensioners' flats

but this was discouraged by the municipal Department of Social Welfare on the ground that it might infringe on the privacy of the residents It was said by an official of the Welfare Department that such an attempt might be regarded more favorably now

USE OF LEISURE TIME

The Gallup Poll of 1951 asked the older people whether they find the day to be tedious The day was seen as going easily by 82 per cent while 8 per cent said that it varies and 9 per cent said that it drags The usual daily activities are listed in Table 11 The residents of Copenhagen were more likely to read take walks, listen to the radio and play cards than were the town and rural people

For most of the people their present activity is something they have done for a long time But 15 per cent started needle work or some other handwork after retiring 10 per cent started reading or listening to music 18 per cent started card playing and 55 per cent of those taking walks have started it since retiring In all cases these are percentages of those who now engage in the activity New pleasures or joys mentioned by the older people were grandchildren (31 per cent) and the Lord the church and the Bible (10 per cent)

There is not much development of facilities for hobbies of older people Some of the pensioners flats have rooms in the basement for arts and craft activities but few of them are in use Sometimes these rooms have been made into an extra apartment At the great municipal Old People s Home in Copenhagen (De Gamles By) there is an excellent occupational therapy unit The program is aimed at helping the individual (1) to feel accepted by the therapist and others (2) to feel useful through making useful and salable things and (3) to form social relationships with the therapist and others Thus this is essentially an ego-support program Apparently its success depends on its direction by a professionally trained person older people are not likely to do this kind of thing on their own initiative

ROLE OF STUDENT

Older people are welcome to take part in adult education activities for mixed age groups of all kinds for example the municipal evening schools and workers' education classes There is no movement to provide group counseling or discussion for people in preparation for retirement

TABLE 11*

ACTIVITIES OF RETIRED PEOPLE IN DENMARK

(Percentage of Those Replying to the Question "What Are Your Main Activities?")

Activity	Women	Men	Total
Looking after the house garden poultry etc	44	40	42
Needlework domestic industry	59	2	33
Reading	30	38	33
Walking riding a bicycle	7	24	15
Visiting	12	14	13
Working for money	4	14	9
Radio-listening	3	6	5
Card playing	2	4	3
Other activities	5	18	11
Total†	167	160	164

* Source Danish Gallup Institute 1951

† Some respondents gave more than one answer

THREE CASES

The paucity of statistical data on the experience of older people in Denmark may be relieved by the following accounts of interviews with three older people all residents of pensioners flats As will be seen there is a considerable range of socioeconomic status among those who are eligible for residence in such flats

Mr Hansen—in the town of A——— This town has built two pensioners' homes one for couples and one for single people The two buildings are adjoining and house about thirty people A matron is in charge The houses are set in a grassy park across the street from the school building

Mr Hansen is in his seventies and has been in his one-room apartment for 5 or 6

years He is a bachelor and has knocked around the world having worked in Argentina and California as a dairy worker In 1936 he came back to Denmark and operated a small farm but later he sold out and did odd jobs until he could work no longer His older sister was already in this home and he followed her

He has belonged to no organizations and says that most people do not belong to organizations other than trade unions He belongs to the local old age pensioners' association which meets two or three times a year for social occasions He enjoys these meetings He does not know who the officers are and says that the association has no political program Mr Hansen enjoys religious services held alternately in this home and the one in a neighboring village a mile away He often walks over to the other home for their service They usually serve coffee afterward

Mr Gravesen —Mr Gravesen is 80 years old With his wife he lives in a two room pensioners flat in Copenhagen He was a barrel builder before his retirement at age 69 When he and his wife became unable to look after their old home they moved to this flat where they have very little housekeeping to do They get a hot meal every noon from a mobile kitchen that serves pensioners flats He belongs to no associations and dropped his union membership when he retired He goes to church occasionally He does not belong to an old age pensioners association He has done no handwork since he retired He likes to read the newspapers and chat a bit with his neighbors He sees his grown children and their families occasionally

Mrs Jensen —Mrs Jensen speaks good English She was the daughter of a land owner in Jutland who sent her to a boarding school in Copenhagen when she was a girl She has traveled a great deal and spent five years in Boston and New York She has a married son and a married daughter in Copenhagen both of whom are fairly well to do Both are now building summer homes and she has just returned from a month s visit with her daughter

Mrs Jensen is an amateur artist and has a nephew who studied art in Paris She bought some of his watercolors just in order to encourage him Being 85 years old and unable to manage a place of her own she feels lucky to have this flat with its services Her only wish is that she had a small bedroom She has not been used to sleeping in her living room Being on the third floor she enjoys the view from her window of a park and football field across the street

Mrs Jensen never belonged to any associations and does not wish for this now She has her own personal religion and does not feel a need for a church She reads a little and does needlework She says I like to have something in my hands She does not care much for radio except for news and good music

C Switzerland

Switzerland is a conservative society with a strong rural tradition that is guarded jealously In 1950 only a third of the population lived in urban places Yet the fact is that Switzerland is steadily becoming more urban and more industrial The labor force has changed from 36 per cent engaged in agriculture and forestry in 1888 to 15 per cent today (These figures refer to those who have been or are active in the labor force) Meanwhile the proportions of people in commerce transportation and the professions have more than doubled The proportion of pensioned persons has more than tripled

While the society has been changing the population structure has been changing also with now almost 10 per cent of the people over 65 Among women widows and unmarried women outnumber the women who have living husbands two to one in the age group over 65 while married men living with their wives outnumber widowers and single men two to one Thus there is a

large group of people, mainly women who are pretty much alone in the world

There is a small old age pension which goes to everybody and which is supplemented by old age assistance grants on the basis of a means test The maximum grant is far below that of the Scandinavian countries

In the rural villages older people have continued to have an economic and family function They can do their share of the work of splitting wood cutting hay and drying it digging potatoes and keeping the tools in repair A farmer ordinarily holds title to his property until his death and he usually lives in his own house with a grown child and grandchildren

The life of an older person has not changed much in the last 100 years in the Alpine villages But the cities have witnessed the usual urban changes Older people tend to live by themselves they are retired from work and have little to occupy their time

ROLE OF CLUB MEMBER

Club life is not generally regarded as necessary for older people and with the exception noted below people are expected to drop out of clubs as they grow older Thus in a study made in a peasant village 14 of 37 women over 60 had been club members but only 3 were now active Among men over 65 16 of 23 had been club members but only 2 were now active

There is the beginning of an old people's club movement in the Zurich area with four clubs The largest of these has been formed by Migros a co-operative society in connection with its Adult Education Center Founded in 1953 with 100 members this club has grown to 500 members with an average attendance of about 180 at the weekly meetings This club has a retired teacher as its principal officer There are only 80 male members Meetings are held in the Adult Education Center with the lounge and buffet always open for card playing, conversation, and coffee-drinking

The club membership is a mixture of social classes The women knit and put together a Christmas box for "the poor people in the mountains" There is a bus tour twice a year to summer resorts as well as weekly excursions in the Zurich area Recently, a group paid a visit to a new church built in 'modern' style They sang hymns together and had a wonderful experience in the sanctuary This club is self supporting

According to the club president, it is difficult to get new things started "The inertia of people is tremendous" he says They tried fitting up a workshop for the older people but few of them came As a rule, they do not go in for study courses A few take part in the regular adult classes run by the society

The president of the club believes that older men have the greatest difficulty adjusting to life in the city They tend to become 'fifth wheels,' without function The best thing for them is a part time job The club keeps a list of men who want employment and succeeds in finding jobs for some of them

Zurich contains about 55 000 older people Perhaps 2 per cent of them have some contact with a club for older people

In the rural villages there are no clubs for older people but the local pastor or priest generally organizes a monthly afternoon meeting except in the summer, when people are busy with household work He leads a devotional service which may be followed by refreshments Since the church leadership tends to operate in an authoritarian manner the old people themselves do not manage these affairs

ROLE OF FRIEND OR INFORMAL GROUP MEMBER

The friendship role is not highly developed Women do not get much opportunity to leave their homes Men are more likely to meet in a park in warm weather Those who can afford it may have a favorite coffeehouse or tavern. Thus in a city of 40 000 the retired middle-class business and professional man may be found either

at the "Three Kings" or "The Star" In the study of a peasant community previously referred to, the women seldom went out, but some of the men went to a *Stammtisch* One man said that his wife sent him to a tavern "to find company," while the grand child of another man said, "On Sunday he goes to the tavern"

ROLE OF CITIZEN

Older men are expected to take a mild interest in civic affairs Women do not vote in Switzerland, a fact which reduces the political power of old people since there are more women than men in the older age group There is no political activity of older people as such and no organization of old age pensioners

In this connection the French language part of Switzerland may be moving toward a greater degree of civic activity Thus recently the organization called Vert Automne, which keeps up the *Wanderwegen* (footpaths) in eastern Switzerland has recruited several hundred older people to work part time on the upkeep of foot paths Although they may get a small amount of pay, the older people see this mainly as a means of being useful to the community

ROLE OF CHURCH MEMBER

People tend to go to church services more faithfully as they grow older and those who have been leaders in the local church council may retain their positions of leadership as long as they wish to fill an active role However, the principal church activity for its older members as such is the monthly service already mentioned

ROLE OF USER OF LEISURE TIME

In the rural villages and in the farm houses the older people use their leisure time by doing simple work around the home They enjoy looking after household s cats, dogs, and birds and caring for the chickens Most older women do needle work Within the family there is some card playing, the favorite game being jass

Among the 60 older people interviewed in the peasant village, 5 women and 2 men played cards a great deal The majority of people read the newspapers and listen to the radio Somewhat over half of the older women and men go for walks, especially on Sunday

In the cities the time is more likely to hang heavily on the hands of older people But they also busy themselves as much as possible with gardening handwork and taking walks

ROLE OF STUDENT

The role of student is not expected of old people, and few of them take part in adult classes There is no educational program of preparation for retirement

CONCLUSION

It might seem that older people in Switzerland lead a dreary life compared with those in Sweden or England, for example But this probably is not true of those in the villages and country, where they retain the functions of the elderly in an agricultural society In the cities their life probably is somewhat dreary At least the people in the social work profession believe that there is need for programs aimed at helping older people find some meaning in life

The Swiss society Pro Senectute is now paying more attention to the problem of ego support for urban old people In addition to its function of providing homes and other material assistance to the needy aged it operates a visiting service Inevitably, older people in Switzerland will look increasingly for meaningful activity outside the work role and outside the family circle

D West Germany

Germany differs from the other Western countries in one important respect she has lost two world wars within the twentieth century with the result that the economic cost has been borne largely by today's older

people, in addition to their personal loss of sons and husbands In 1923–25 there was a ruinous inflation that wiped out the savings of most ordinary people, and in 1945–48 there was an inflation terminated by currency reform that confiscated the largest part of the savings of the "small people"

Thus old age has come to have the connotation for Germans of poverty and misery But this is juxtaposed with a tradition of respect for authority, which is generally associated with old age and especially with the elderly man as head of a family Some 10 per cent of the population in West Germany is over 65 and this will increase to perhaps 12 per cent in the next 10 years Berlin now has 14 per cent over 65

Interviewing a sample of working class and lower middle-class people aged 20–64 Friedeburg (1955) found that 75 per cent of these people thought that the economic situation of old people receiving social security benefits in Germany today was "bad" or "very bad" while only 2 per cent thought that it was "good" When asked whether they expected old age to be a "good" or "bad" time for them 19 per cent thought that it would be a "good" time 29 per cent thought that it would be "not so good", 10 per cent thought that it would be "bad" and 45 per cent could not say Recently the economic situation of the elderly has been somewhat improved by a new pension law which brings nearly everybody *into the* social security system and which has raised the level of payments somewhat

Germany established the first system of social insurance in Europe and consequently the people have had a long time in which to become accustomed to the state as an agent for their economic welfare Perhaps for this reason as well as others the German people generally appear to accept and adopt a more passive attitude toward their old age than do people of other countries They accept retirement from work as a matter of course and in a recent study of public opinion they indicated that the preferred average age for retirement was 63 4 They accept a system of government supported pensions and favor its extension to practically all people

"independent" occupations—law, medicine, small private businesses, and certain skilled trades They have not in the past been covered by social security laws A recent study of these people indicates that they have managed to get along in the difficult periods of the current century remarkably well They continue to work as long as possible, generally until 70 or 75 They may have private insurance or annuities In case of serious difficulty they *secure help from their families* or other private sources They may be described as the most "autonomous" of old people in Germany

The need for housing of the elderly is rather poorly met in Germany, mainly because so many houses were destroyed during the war that an acute housing shortage has existed for all segments of the society Nevertheless, there is a tradition of several centuries of old people's homes, and this type of housing is rather plentiful Thus, in 1956 there were 729 Evangelical church old people's homes in West Germany with 147 000 beds, or enough for about 3 per cent of the population over 65

In postwar years there have been a few pensioners' flats erected at public expense in such cities as Hamburg These are similar to those in Denmark but are not so numerous

The urban rural contrast of living arrangements is striking in Germany For example, Table 12 compares the living arrangements of people in a rural peasant community with that in a non homeowning section of a large city This table shows that the three generation family is quite common in the village but almost non-existent in the city A study comparing living arrangements of people over 65 in several different types of communities gave the following results concerning the percentages of older people living in a three-generation

at the "Three Kings" or "The Star" In the study of a peasant community previously referred to the women seldom went out, but some of the men went to a *Stammtisch* One man said that his wife sent him to a tavern *"to find company"* while the grandchild of another man said "On Sunday he goes to the tavern

ROLE OF CITIZEN

Older men are expected to take a mild interest in civic affairs Women do not vote in Switzerland, a fact which reduces the political power of old people since there are more women than men in the older age group There is no political activity of older people as such and no organization of old age pensioners

In this connection the French language part of Switzerland may be moving toward a greater degree of civic activity Thus recently the organization called Vert Automne which keeps up the *Wanderwegen* (footpaths) in eastern Switzerland has recruited several hundred older people to work part time on the upkeep of foot paths Although they may get a small amount of pay, the older people see this mainly as a means of being useful to the community

ROLE OF CHURCH MEMBER

People tend to go to church services more faithfully as they grow older and those who have been leaders in the local church council may retain their positions of leadership as long as they wish to fill an active role However, the principal church activity for its older members as such is the monthly service already mentioned

ROLE OF USER OF LEISURE TIME

In the rural villages and in the farm houses the older people use their leisure time by doing simple work around the home They enjoy looking after household s cats, dogs, and birds and caring for the chickens Most older women do needle work. Within the family there is some card playing the favorite game being jass

Among the 60 older people interviewed in the peasant village, 5 women and 2 men played cards a great deal The majority of people read the newspapers and listen to the radio Somewhat over half of the older women and men go for walks especially on Sunday

In the cities the time is more likely to hang heavily on the hands of older people But they also busy themselves as much as possible with gardening handwork and taking walks

ROLE OF STUDENT

The role of student is not expected of old people, and few of them take part in adult classes There is no educational program of preparation for retirement

CONCLUSION

It might seem that older people in Switzerland lead a dreary life compared with those in Sweden or England for example But this probably is not true of those in the villages and country where they retain the functions of the elderly in an agricultural society In the cities their life probably is somewhat dreary At least the people in the social work profession believe that there is need for programs aimed at helping older people find some meaning in life

The Swiss society *Pro Senectute* is now paying more attention to the problem of ego support for urban old people In addition to its function of providing homes and other material assistance to the needy aged it operates a visiting service Inevitably older people in Switzerland will look increasingly for meaningful activity outside the work role and outside the family circle

D West Germany

Germany differs from the other Western countries in one important respect she has lost two world wars within the twentieth century, with the result that the economic cost has been borne largely by today's older

them, work is likely to be the principal axis of life, and the psychological significance of their work is likely to be different from that of the Rhinelanders The latter are reputed to like a kind of work that brings them in contact with other people They are more likely to enjoy the life of social groups than the more individualistic northerners

ROLE OF CLUB OR ASSOCIATION MEMBER

There is a saying in Germany that, when three Germans get together, they found a society ' It is not clear whether this is more true of Germans than of other national groups, and similar statements are current concerning others But it is true that Germany has a large number of organizations for men and some for women and that these are not limited to middle class people The social expectation is that people will continue to take part in the formal associations of their adult years but with some decrease of interest and activity

There appears to be a slight decrease of club activity after about age 60 Reigrotzki (1956)[2] found in his adult sample that 60 per cent of the men over 60 and 34 per cent of the women were members of some organization (including church societies), compared with 73 and 37 per cent of the entire adult group Men belonged to 1 68 organizations on the average and women to 1 28 Neuloh (1956–57), in his study of retired miners found that two-thirds of them claimed to be as active as ever in organizations, while 20 per cent said that they had withdrawn from associations of ten b

sample found that trade union membership for men dropped from 28 per cent of those aged 45–59 to 12 per cent of those over 60 It appears that Neuloh s miners in the Ruhr area kept up their union activity more than the average trade-union member and, in addition, took part in associations for gardeners, small animal breeders, and for amateurs of sport and hobbies

When it comes to clubs for older people, the German experience is just beginning There are a few old people's clubs in the larger cities, but they are generally new and experimental There is no organized club movement for older people, and the writer could find no instance of a club organized by and for older people The closest approach to this is in West Berlin, where a substantial program of social centers has recently been established by the social welfare authorities. In these social centers a number of interest groups have developed, led by older people For instance, one of them has nine such interest groups (literature, music, etc)

At present it would appear that such old people s clubs as do exist in Germany are generally organized by social workers and that they serve as places for informal social activity for older people They are not much like the formal self governing associations of the middle aged group

In summary, it may be said that formal associations are of significant value to older people in Germany, who tend to retain their membership in them as they grow older These associations are mainly for urban people Men get more value from them than women do Working class people enjoy them as well as middle-class people

ROLE OF FRIEND OR MEMBER OF INFORMAL SOCIAL GROUPS

As in other countries, the informal social relationships of older people are regarded as desirable, but not much is done to promote them. The striking exception to this statement is provided by the experimental program of social centers established in 1957 in West Berlin Thirty centers have been set up there by the social welfare au

[2] Erich Reigrotzki, of the Institut fur Demoskopie, Allensbach Bodensee made an interview study of a national sample of adults in 621 communities, with 3245 interviews in 1954 A good part of the data reported here is from his study

family rural village, 55, workers' suburb of a city, 53, new middle-class suburb of a city, 19, a community of refugees from Soviet occupied areas, 16, and a rented house area of a large city, 13

Taking all West Germany, 26 per cent of people over 65 were living only with a spouse in 1950, while another 13 per cent were women living alone, and 5 per cent were men living alone The preferences of men aged 20–64 concerning living arrangements are reported, as shown in Table 13, by Friedeburg Here the urban rural contrast is visible again, with 47 per cent of the rural men preferring to live alone with their wives, as compared with 80 per cent of the city dwellers If older people do not have a function in the family, it is regarded as desirable for them to live apart For instance, one elderly lady used to darn the stockings of the family She now lamented her loss of function, saying "Now they have nylons and there is nothing for me to do"

Since there has been more research on social aspects of old age in Germany than in the other Continental countries, we will report more fully on Germany, remembering that the social situation is about the same for elderly people in West Germany as in Switzerland and Denmark, though their economic situation is at present somewhat worse The need for ego support of older people, however, is beginning to be talked about in Germany, though it is believed that the needs for economic security and for comfortable housing are somewhat more pressing

In considering the experience of older people in Germany, it is well to remember that Germany is a heterogeneous country with people from several different culture streams Therefore no generalization about German" expectations or social roles is likely to be equally true of all sections of the country For instance the North Germans are reputed to be a very serious industrious and work minded people For

TABLE 12*

LIVING ARRANGEMENTS OF THE POPULATION IN TWO TYPES OF GERMAN COMMUNITY

(Per Cent)

Living Arrangement	Non home-owning Section of Large City	Rural Peasant Village
Living together as married couples with or without children	50	55
Living in three generation families	4	43
Broken families living alone with non relatives or one sided family (e g mother with children)	46	12

* Source Sepp Groth *Soziale Welt* (Göttingen) 4 (1953) 205 ff

TABLE 13*

LIVING ARRANGEMENTS PREFERRED BY MARRIED GERMAN WORKING CLASS AND LOWER MIDDLE CLASS MEN WHEN THEY RETIRE

(Per Cent)

Living Arrangement	Population of Place of Residence				
	Under 2000	2000–4999	5000–19 999	20 000–99 999	100 000 and Over
With children	36	33	16	12	7
With friends and relatives	3		5	1	1
With wife	47	54	63	71	80
Entirely alone	3	6	7	4	4
No answer	11	7	9	12	8

* Source L. von Friedeburg *Altersbild und Altersversorge der Arbeiter und Angestellten* (Frankfurt Forschungsbericht Inst für Sozialforschung Universität, 1955) p. 63

other areas and that there is more interest in domestic politics than in the national or international variety

There is a Vereinigung der Rentner ("Union of Pensioners"), with headquarters in Frankfurt, and organized groups in several other cities It is not nearly so active as the ones in Scandinavia

ROLE OF CHURCH MEMBER

The general expectation in Germany is that, as people grow older, they will attend church more often and become more religious in their attitudes However, they are not expected to take a more active part in church leadership simply because they are growing older In the Protestant churches there are local church councils which provide lay leadership A person serves on the council as long as he is able and willing He is not arbitrarily retired on account of his age But people are seldom recruited for new positions on a church council if they are already old

The actual data on church attendance according to Reigrotzki s study (1956), indicate that people 60–79 attend church more regularly than any other age group It is also striking that men in the older age bracket attend church more often than women, which reverses the sex differences that appear in the earlier ages It is not clear just what this means There may be more old women who are invalids and unable to attend church or the self reports of the two sexes may differ in accuracy

Although the church leaders in Germany are just beginning to become concerned about the problem of old age, they are much more concerned with youth problems For instance a Frankfurt newspaper published two leading articles on the typical city church as seen by the clergyman in the spring of 1957 One article was by a Protestant and the other by a Catholic clergyman Both had churches in suburbs of large cities with mixed socioeconomic populations. Both men recounted the work of a typical week Both accounts were full of comments on the youth program, for which there was a special assistant The Catholic pastor did not mention the old people at all The Protestant pastor spoke of a small group of older members who gathered in the parish house once a week for coffee and of another group with pietistic leanings who consisted mostly of older people and who met for a weekly prayer meeting in the church On the other hand in 1956 there was a meeting of church leaders on the subject of the church's responsibility for work with older people which resulted in a series of conclusions and recommendations, including a program of counseling, of social activities, and of interest in the economic welfare of the older people

ROLE OF USER OF LEISURE TIME

It is not expected in Germany that older people will discover or develop new leisure activities or that they will be strenuously active in such things An exception to this general statement occurs in the case of some upper and upper middle-class people who specialize in certain types of conspicuous leisure activity such as travel studying genealogy, collecting, painting and joining groups which are interested in local history

It is expected that older women will do handwork and that older men will sit and talk with their friends In addition, it is expected that certain leisure habits of earlier years will be intensified, such as gardening and raising small animals

In practice, people seem to continue the leisure activities already started and to intensify some of them For example, Neuloh (1956–57) reports that there is much interest in small animal raising by older people in the Ruhr region, especially of goats Also the miner traditionally had his pig and insisted on having a pigsty in the new postwar model houses Among Neuloh's retired miners, 67 per cent had gardens on their own land or on rented land, with 100–800 square meters of surface Friede

thorities At first they were open to all elderly people regardless of their economic status, but they were so well patronized that rules were drawn up giving preference to people who were in special need of them —usually working class people These centers seem to provide a place for informal association with other people for "passing the time" Men play cards and smoke and talk, women do handwork and talk

The old people's clubs which have been started by social workers in other cities also seem to serve the function of providing a place and a stimulus for friendship activities The same thing can be said of the Quaker neighborhood centers in several German cities, which serve the entire age range in a neighborhood, but usually have an informal old people s group The social center movement is thus getting a trial in Germany, but whether it will work out remains to be seen since earlier attempts at developing social centers for all ages in the public housing units have not succeeded The quarters designed for social centers have generally been turned into living quarters The writer visited some of the housing projects for elderly people built by the city of Hamburg These do not have room for communal social activities they are simply pleasant apartment buildings in which each elderly couple and single person have their own quarters but are not encouraged to develop a community social life

It is generally supposed that men get more out of informal social activities than do women and that they need this more The woman is busy with her household work and may get time to gossip with her neighbors But her husband if he does not have work is likely to mope around the house and to get in her way So she sends him out to talk with his cronies in the park if it is good weather When he can afford it, he goes to the neighboring *Stammtisch* to read the papers, talk with friends and drink beer or coffee If he cannot afford this, he spends the good weather out in the sun in a park or on a bench by the river In bad weather he may seek a warm room such as a free reading room in a library or a newspaper office

Germany has not developed any "old people's resorts" like the Florida communities or Torquay on the south coast of England One reason is that there are no really warm winter resorts in Germany, and another is that there are not many older people who can afford such a trip Still, one can see a substantial number of elderly people in the once-fashionable spas of Germany in the summer For those who can afford it, the annual visit to a spa provides a pleasant outing and offers some opportunity to make friends and to be with friends

In general, it seems that informal friendship activity is not an important source of satisfaction to many older people in Germany It is perhaps more important to the elderly people of the villages and to a minority of people, mostly men, who have retained their earlier habits of frequenting social clubs and meeting places and have enough money to meet the expense of continuing these habits

ROLE OF CITIZEN

The German public accepts the activity of older people in politics and respects the wisdom of old age The age of Chancellor Adenauer is not regarded as a handicap Some of the older Social Democrats and trade union leaders continue to be quite active

Reigrotzki (1956) found a small dropping off in voting and political activity after age 60 but it was very small Older women are more likely to cease voting than older men Neuloh s study (1956-57) of retired miners in the Ruhr area found that 40 per cent were actively interested in politics Eighty per cent knew their local mayor's name and many knew him personally Ten per cent of these men have an unpaid office in the political life of the community It appears, then, that there is more interest in civic affairs by older people in the industrial than in the

usual trend In the Netherlands there are relatively fewer elderly widows than in other countries Among women aged 65 and over, there are almost as many women living with their husbands as there are widows

A state old age pension without a means test has been in force since 1957

The remarkable thing about the life of older people in the Netherlands is the extent to which they are organized into associations. Because of the religious and political heterogeneity of the people, combined with the strength of their religious ties, there are a large number of associations of older people About 35 per cent of the older people are Roman Catholic, 41 per cent are Dutch Reformed, 7 per cent belong to the "Reformed" Dutch Reformed *Church, which* is more conservative in its

The religious divisions are so important in the eyes of the Dutch people that they have their own radio associations and programs As a matter of course they run their own schools Moreover, they have their own training schools for social workers and their own old age associations

ROLE OF CLUB OR ASSOCIATION MEMBER

Although the Dutch do not think of themselves as "club-minded" they have made more use of clubs for older people than probably any other country In fact it appears that clubs are more general in Holland than in most countries The ordinary *Dutch* community has its football club and clubs for gardeners pigeon raisers, photographers amateur dramatists, and fishermen There is generally a large "association of housewives" In one particular community of 60 000 inhabitants, thirty brass bands turned out for a community festival Thus clubs or associations of various types and sizes are very common in the Netherlands.

These clubs have a fairly wide social class range of members, with their greatest numbers from the lower middle and upper working classes Upper middle-class people are less likely to be club minded The director of a university institute commented on the club activities of the concierge of his building When asked how he was going to spend the next week end this man said "Oh, we've got the Anglers' Club this evening, and then tomorrow afternoon the Football Club has a game, and I shall have to talk over Garden Club purchases of fertilizer with a committee on Sunday There's always something to do."

Men belong to associations more than do women The latter are expected to be at home or possibly to attend women's associations. Persons do not drop out of associations merely because of age, though they often resign because of expense or because, as they grow older, they lose interest in

Old

four ma

the Netherlands Three of them are neutral in religious matters (Bond voor Staatspensionnering, Algemene Nederlandse Bond voor Ouden van Dagen, and Federatie van Bonden van Ouden van Dagen) The fourth (Unie van Diocesane Bonden van Gejaarden en Gepensionneerden in Nederland) is related to the Roman Catholic church These four associations work *together in* the national Contactorgaan van Samenwerkende Organisaties, and they all have in their program the improvement of the material position of the aged and the stimulation of good recreation Probably *300,000* of the Netherlands' 950,000 people over 65 pay dues to one of these organizations, receive its monthly or quarterly journal, and attend one or several meetings a year

As for office-holding 3 9 per cent of a national sample said that they now hold office *in an association*, with church and social organizations the most popular

Old people's clubs—The four general associations mentioned *above* have as a *major activity* the sponsorship of clubs for older people and probably account for a total of about 1000 clubs The number has

burg (1955) found gardening to be the favorite anticipated leisure activity of his sample aged 20–65.

Table 14 shows what people expect to do with their spare time when they retire. Table 15 reports the preferred leisure activities of adults of all ages

TABLE 14*

ANSWERS TO QUESTION OF NATIONAL SAMPLE OF GERMAN MEN AGED 20–65†

("What Do You Expect To Do When You Retire?")

(Per Cent)

Do gardening or raise small animals	44
Go for walks	33
Follow leisure interests (art, radio, science, reading, etc)	31
Work for extra income	11
Work around the house, make myself useful	11
Total	130‡

* Source L von Friedeburg *Altersbild und Altersvorsorge der Arbeiter und Angestellten* (Frankfurt Forschungsbericht, Inst für Sozialforschung Universität 1955)

† [illegible]

‡ Some persons gave more than one answer

ROLE OF STUDENT

Adult education is fairly well developed in Germany through the folk high schools, and a small proportion of older people enrol in these institutions for courses in "cultural" subjects. There is no adult education for old people as such, though there is *some talk of experimenting with discussion* groups on problems of retirement. Those older people who have led a life of scholarship, whether in teaching or in research, are welcome to go on with this work even after they retire with a pension.

E. The Netherlands

The Netherlands has experienced a relatively recent industrialization and has maintained a high birth rate which has kept the proportion of aged people at the lowest level of all the northern European countries. The proportion of people over 65 changed from 4 7 per cent in 1849 to 8.5 per cent in 1957. The ratio of women to men aged 65 and over has decreased from 1 27 in 1849 to 1 10 in 1947—an un-

TABLE 15*

PREFERRED LEISURE ACTIVITIES OF GERMAN PEOPLE

("If You Had More Money and Time, What Would You Do with Them?")

(Per Cent)

Activity	Men					Women				
	18 24	25 29	30 44	45 59	60 and Over	18 24	25 29	30 44	45 59	60 and Over
Travel	59	65	59	55	40	65	68	63	50	41
Entertain neighbors	5	8	7	13	9	6	11	10	11	11
Read	23	38	25	23	23	28	34	31	29	23
Go to theater	22	36	25	26	17	41	38	37	26	25
Spend time with family	15	40	47	52	40	35	43	51	48	42
Handwork, hobbies	27	30	24	27	18	39	42	37	25	22
Political activity	8	7	7	9	10	1	4	2	1	3
Take part in church activity	1	8	6	12	16	6	9	10	15	21
Do more in local community activity	5	3	7	6	11	7	7	8	13	16
Play sports	50	14	20	17	5	31	18	11	6	
None of these	4	3	5	9	24	5	4	7	13	22
No of respondents	(195)	(158)	(463)	(437)	(324)	(230)	(215)	(618)	(518)	(207)

* Source E Reigrotzki, *Soziale Verflechtungen in der Bundesrepublik Elemente der Sozialen Teilnahme in Kirche Politik Organisationen und Freizeit* (Tübingen J C B Mohr, 1956)

cities and towns than in the rural villages, where the old people are not so much recognized as a group apart but fit into the normal family life

Upper middle- and upper-class people rarely belong to clubs for old people They meet in their own types of social clubs, which are not divided along age lines but in which older people usually have the leading positions But these clubs have a limited significance in the social lives of upper middle- and upper class people On the whole, they use their homes as a basis for their social relations There are only a few English style social clubs in the Netherlands, such as De Grote club in Amsterdam and De Witte in The Hague

ROLE OF FRIEND OR INFORMAL GROUP MEMBER

To a considerable extent the old people's clubs provide a basis for informal friendly relations Supplementing them are a few social centers such as the one sponsored by the United Volunteer Women in Arnhem Here a building staffed by UVW members, is open all day

Old men often have favorite meeting places in a park, on benches near a harbor or in a cafe

Generally speaking old people are not expected to make new friends easily, and it is thought that older people suffer from social isolation as they grow older But some persons do make new friends in the clubs The physicians who collected the data for van Zonneveld s (1960) study rated the people whom they knew as lonely and/or withdrawn in 19 per cent of the cases of men and 24 per cent of women (preliminary report on the first 1000 cases)

Table 16 shows how the regular social contacts, with friends and families, are related to age

ROLE OF CITIZEN

Older people are expected to become less interested and less informed on civic matters and to be "set" in their political opinions The old people's associations have a potential, if not an actual, political significance They are capable of providing a good many votes on a proposition of special interest to older people For example, the Algemene Nederlandse Bond voor Ouden van Dagen, which is neutral in a religious sense, had 74,000 members in 1957, in 225 local sections Its official purpose is to promote a better housing and financial position for the elderly and good leisure activities

More explicitly political is the Bond voor Staatspensionnering (Association for a State Pension), with 160,000 members in 1957, not all of whom are old people, a monthly newspaper, and meetings of local branches one to three times a year Having achieved its goal of a general state pension for the aged, it now works for adequate housing, greater recreational facilities provision of adult education, and the improvement of the morale of the aged

TABLE 16*

PEOPLE HAVING REGULAR SOCIAL CONTACTS IN THE NETHERLANDS

(Per Cent)

Age	Face to Face	By Correspondence
65–69	80	42
70–74	76	38
75–79	73	35
80–84	73	31
85 and over	71	23

* This table is from a public opinion study made in 1951 52 by interviews with a quota sample of 11 304 people in 155 communities The women s sample was biased toward women without husbands (see J D edrich, *Report of a Survey of Older People, 1951 52* [Amsterdam Bureau voor Marktanalyse en Sociografisch Onderzoek 1953])

ROLE OF CHURCH MEMBER

It is expected that older people will become more religious and more faithful in church attendance, and this does happen except for a decrease of attendance after age 75, as can be seen in Table 17. The

been growing very rapidly since 1954 Moreover, there is quite a number of old people's clubs related to the Dutch Reformed and the Conservative Reformed *parishes, without a separate organization* A number of other organizations which do not consist *primarily of older people* support and conduct old people's clubs For instance, the Union of Volunteer Women conducts 150 clubs, the Salvation Army has a club program, and the Protestant Christian Women's League sponsors clubs It is estimated that probably 100 000 Dutch people are now members of *old people's* clubs, or about 11 per cent of the population over 65

A major reason for the relatively large development of clubs in Holland is the fact that many local municipalities will pay about half of the running expense of a club through a system of grants approximately matching the fees paid by members themselves The members generally pay about 10 cents (Dutch) a meeting The *municipality subsidizes a club in proportion* to its attendance Other expenses such as those of furnishing the club quarters may be paid by the church organization or other sponsoring groups

Possibly another reason for the success of old people's clubs is that most of them *are backed by church organizations which* in the Netherlands have vigorous programs for the social welfare of their people There is a committee on the welfare of the aged in each major denomination and in each major district which is constantly looking for opportunities to develop clubs and other *activities These committees for the aged* should be clearly distinguished from the associations *of* the aged

Nature of clubs—In the Netherlands there is general agreement that clubs should not exceed fifty members Some organizations set a limit at twenty or thirty while others *allow a club to grow to a* hundred members but do not expect an attendance of more than fifty at a meeting Clubs usually meet once or twice a week, in the afternoon, often in a room in the parish house of the church The program is informal, with cards, films, phonograph recordings, occasionally a talk, and exchange of books Excursions may be arranged, and there may be joint meetings with other clubs

Leadership is provided by the members themselves or by middle aged people who volunteer their services, especially in the Roman Catholic organization the principle has been adopted that leaders both of local clubs and of the Old People's Association should be themselves older people Thus some clubs are run by older people for themselves, while others are run by middle *aged people for older people*

Most clubs have *more men than women* in active participation This is different from the clubs in most other countries When asked to account for this difference Dutch informants generally remark that club work is regarded as a man's activity in the Netherlands *Most clubs adhere to a* principle of mixed membership There are *a few women's clubs such as the* successful farm women's clubs in Friesland One explanation given for the predominance of men in the clubs is that the Netherlands has relatively fewer widows than other countries, and widows are more likely to join clubs than are women with husbands

The clubs show a leaning toward a working class composition Trade union members seem to gravitate easily into clubs as they grow older, and trade union leaders are likely to become club leaders The Catholic Old People s Association was founded by Catholic trade union leaders *Even today, middle-class Catholics* are said to hesitate to join their Old People's Association

One way to broaden the base of membership is to develop several clubs sponsored by a given church in a community This has happened in Utrecht, which has *twenty clubs under the auspices* of the Reformed church, the various clubs tending to consist of people of like social station and similar interests

There are more old people's clubs in

but there are few adult education activities planned for older people. A few industrial concerns are beginning to take an interest in preparing their employees for retirement.

F. *Great Britain*

Great Britain has one of the most mature populations in the world, being exceeded only by France and Belgium in the proportion of people over 65 years of age. England's population has aged very rapidly during the present century, having more than doubled its proportion in the over 65 group.

Aging has been recognized as a social problem for a considerable time in Britain, primarily as a problem of social welfare. The first surveys of the status and problems of older people were made in England. In response to the findings of widespread loneliness as well as of need for financial assistance and physical care, there has developed a considerable social apparatus. Several social services help meet these various needs, such as the Home Help Service and the district nursing and welfare services.

Britain has invented a social instrument for the welfare of the aged in the form of the Old People's Welfare Committee, organized on a local community, a county, or a regional basis. The committee consists of representatives from voluntary and statutory bodies concerned with the elderly. Sometimes there is a social worker as the organizer and executive officer. Legislation of 1948 permits a local governmental authority to pay the salary of an organizer and to provide modest grants for the work of an Old People's Welfare Committee. In 1958 there were 1339 committees, but only a minority of communities provided for a paid staff member.

The old people's welfare committees work together through the National Old People's Welfare Council with headquarters in London. This council issues bulletins and has several national committees to promote clubs, housing and home services and the training of volunteers for work with the aged. Funds from the King George VI Foundation have been used to pay for training courses, with an enrolment of over two thousand persons.

The National Old People's Welfare Council (1955) has issued a circular to old people's welfare committees with suggestions for the following services:

Friendly visiting—Bringing needs of the elderly to the notice of voluntary societies and statutory authorities—Making known to the old people themselves help available—Social and other clubs—Assisting enquirers to find ac [illegible] craft and other classes—Publicising or initiating occupation or employment schemes—Mobile Library Services—Aids for infirm, sick and handicapped persons—Holidays—General information and advice—Club Conferences—Conferences and meetings for voluntary workers—Old People's Days or Weeks—Transport by cars, specially adapted vehicles or wheel chairs—Film shows and recreation for the housebound and in clubs—Shopping, reading, preparing house for return of old person from hospital and other individual services.

To see how a committee operates under favorable circumstances, we may use as an example the Old People's Welfare Committee of Hammersmith, one of the central western sections of London, which has a considerable working class population. This borough has a total population of about 120 000, of which about 13 000 are over 65, with a ratio of women to men of almost two to one. The Old People's Welfare Committee started as a private organization during World War II and now has eight members from the Hammersmith Borough Council, eight members from voluntary service organizations, and a councilor as chairman. A full time executive secretary, or organizer, is paid by the council, which provides between £4000 and £5000 for the work of the committee. This committee sponsors the following services for older people: mobile library service,

attendance at most churches is heavily *weighted toward the older ages* Older people get some opportunity for service to the church through retaining leadership positions until they are *fairly well along in* years The Reformed church has a rule that pastors must retire at 65 and lay officers at 70

ROLE OF USER OF LEISURE TIME

The most effective influence on older people's use of their leisure time in the Netherlands is probably the old people's *clubs, though, of course, the leisure activ*ties of middle age continue as they do in other countries People are expected to do fairly much what they have been doing only more of it, as they grow older The men tend to garden, fish, and play cards the women, to knit Table 18 shows the principal free-time activities as reported in Diedrich's (1955) survey In van Zonneveld's study (1960), 45 per cent of men and 41 per cent of women reported that they had at least one hobby Thirty seven per cent of the men said that they were *still working though many of these were* officially "retired," and 48 per cent said that they did *not* enjoy retirement

Although reading was not mentioned often as a special interest, when a direct question was asked, 12 per cent of people over 65 said that they read "much" and 33 per cent said that they read "regularly" Listening to the radio was reported as "much" by 8 per cent and/or "regularly" by 35 per cent Preferences among radio programs are listed *in Table 19*

TABLE 17*

REGULARITY OF CHURCH ATTENDANCE AMONG OLDER PEOPLE IN THE NETHERLANDS

(*Per Cent*)

Age	Male	Female	Both Sexes
65–69	52 4	53 9	52 8
70–74	49 4	44 2	47 7
75–79	43 3	39 5	42 0
80–84	34 6	25 0	30 7
85 and over	21 7	14 3	18 6

* This table is from a public opinion study made in 1951 52 [illegible] sample of 11 304 people in 135 com [illegible]

TABLE 18*

USE OF FREE TIME BY OLDER PEOPLE IN THE NETHERLANDS

(Per Cent)

Type of Activity	Men	Women	Both Sexes
Gardening helping on farm	32 0	6 5	25 0
Handwork hobbies	8 0	66 8	24 2
Games music etc	20 8	9 5	17 7
Sports—active (fishing etc)	20 0	3 7	15 5
Reading	6 8	10 1	7 7
Raising animals	6 6	2 9	5 5
Smoking	4 5	0 1	3 3
Study administration	1 3	0 4	1 1

* [illegible] opinion study made in 1951 52 [illegible]

TABLE 19*

PREFERENCES OF OLDER PEOPLE AMONG RADIO PROGRAMS IN THE NETHERLANDS

(Per Cent)

Type of Program	Male	Female	Both Sexes
Church service	29	54	36
News	35	13	29
Light music	18	19	19
Plays	6	5	5
Classical music	4	5	4
Readings	4	3	4
Sports broadcasts	2	0	1
Children's choir	1	2	1

* This table is from a public opinion study made in 1951 52 [illegible]

ROLE OF STUDENT

Older people are welcome in adult education activities for groups of mixed ages

number of ex servicemen's clubs and women s clubs which have a large old age membership

Nature of old people's clubs—Most old people's clubs are organized and led by middle aged members of voluntary organizations, such as the Women's Voluntary Services or the British Red Cross, or are organized and sponsored by the local Old People s Welfare Committee. However, there are also a number of clubs run by older people, including those which are organized and operated by the Old Age Pensioners Association where the leadership is in the hands of pensioners The Federation of Old Age Pensioners has a political program while the clubs sponsored by the Old People s Welfare Council do not In a particular area in Kent there are six clubs sponsored by the FOAP and twelve by the OPWC Here the Old People s Welfare Committee is 10 years old and consists of representatives of organizations with an interest in old people including a representative of the old people s clubs and a representative of the Old Age Pensioners Association The first club was started in 1947 Average attendance is about 75 of a membership of from 80 to 100 Meetings are held weekly Each of the OPWC clubs has a clergyman sponsor and may meet in the church hall though the church does not sponsor the club Each club has the head master of a local primary school as an adviser who arranges for children of his school to take part in the club's Christmas festival etc The local municipality gives the OPWC a small fund which it divides among the clubs at the rate of about £5 a year Members usually pay 4d–6d a meeting Club members are generally working class people Some have a little money and others receive money from their children In this community 90 elderly people paid 11 guineas for 2 week lodging on a vacation tour to Paignton a summer resort, in 1958

Another example of club structure is given by the town of High Wycombe with about 4000 people over 65 and ten clubs with 700 members, or about 18 per cent of the older group Here there are three women's clubs, three men's clubs, and four mixed clubs Six of these meet in church halls, two in British Legion halls, one in a community center, and one (a mixed club) in a tavern or public house There is no Federation of Old Age Pensioners in High Wycombe, though there is one in a neighboring town The Old People's Welfare Committee is made up of representatives of several agencies, including the Central Aid Society, a private welfare organization of long standing in the community Leaders of the clubs are mainly people in their fifties There has been no change in leaders, except in the case of the oldest club (12 years), whose first leader moved out of the community Each club has its own visiting committee, which organizes visits to club members who are ill

The club structure in a London borough is illustrated by what exists in Hammersmith Here the old people's clubs are under the supervision of the community recreation officer, an unusual arrangement. There are ten clubs, of which eight meet in church halls one in a school in a housing project, and one in a rented hall Sponsorship is provided by the Red Cross the Women s Voluntary Services the Old Age Pensioners Association (two clubs) and churches They meet once or twice a week in the afternoon Membership in the clubs is concentrated among women—and among the more active women Thus, in a study of a sample of 100 people over 70 in this borough Miss Slack (1954) found that 13 of 69 women were club members while none of the 31 men belonged to a club Of the women 11 were widowed or single, and all belonged to clubs with mixed membership Seven of the women were members of two clubs Forty-one persons in the sample were homebound and thus could not get out to club meetings The other principal reason given by non members for not joining a club was "lack of interest" or definite "dislike' of clubs

The old people's club movement has

reduced rates for cinema and concert tickets and on boot and shoe repairs home craft and handicraft classes counseling service foot clinic friendly visiting hair dressing service at reduced rates legal advice mobile meal service luncheon clubs radio receiver loan housing information and holiday excursions

The general British experience is that people under 70 tend to be fairly autonomous and respond to facilities which enable them to plan and act for themselves while people over 70 tend to be more passive asking for little more than to enjoy their last years in peace and more content to make the best of their circumstances rather than to alter them But this generalization must be qualified by considerations of socioeconomic status—the higher status people being more autonomous—and by considerations of personality differences Some of the single and widowed women over 70 are quite active and autonomous

A survey made by the National Federation of Community Associations showed some of these things To a questionnaire sent out in 1954 ninety nine community associations reported on what they were doing to assist old people to continue a normal community life In general it was indicated that older people are seldom active in the affairs of the association but that they are likely to be involved in the activities of people of their own age Some of these groups are quite autonomous under the leadership of older people For instance one association reported that our Good Companions are very independent and entirely run their own affairs Another report stated Our Old Age Pensioners Association which was organized by and is an activity of the Center retains almost complete independence They are so strong and active that their other name is the Youth Club

On the other hand other associations reported apathy on the part of older people even when strong efforts were made to provide programs for them One report said

Perhaps the answer to our particular problem lies in the fact that the Old Age member that we get is the residue of the Industrial Revolution They have all had to work long hours for very little money in the Heavy Steel Industries or the Mines and without being unchristian and uncharitable I think it is fair to say that all they ask is that you leave them alone to play dominoes until the undertaker calls for them Many of them are barely literate—they can just read a newspaper but seem to have no understanding of the problems of the day and do not want to be bothered to learn

ROLE OF CLUB OR ASSOCIATION MEMBER

In Britain the role of association member is an important one for adults Members of the upper and upper middle classes are likely to belong to social clubs as well as to civic organizations and they retain their membership after they retire from work Minor leadership positions often go to older men There also are workingmen s clubs often with their own premises and sometimes meeting in taverns The workingmen s club is often quite important in the life of an older workingman

Old people s clubs generally attract women and men of working class and lower middle class levels About three-fourths of the members are women a contrast with the Netherlands where the relative number of club members is about the same but where men outnumber women

In Britain there were estimated to be about 6000 old people s clubs in 1957 as against 4000 in 1954 Assuming an average membership of 75 this gives a total of 450 000 club members in a population of about 5 000 000 or 9 10 per cent Townsend (1957) has estimated that 10–11 per cent of old people are members of clubs and cites one city (Ipswich) where 20 per cent are members Remembering that women outnumber men three to one in old people s clubs (and also that women outnumber men in the old age population) it may be that as many as 15 per cent of older women are club members and possibly 6 5 per cent of older men There are also a

and the inadequacy of pensions and proud stories were told about children

The men many of them in white silk scarves and caps mostly gathered together in groups away from the women partly perhaps because they seemed to be under represented in numbers One had a box camera and was at pains to take good photographs During the midday meal only the nearest score of people or so could hear the speeches and the great majority continued eating or talking in complete innocence of the words of welcome After the meal a long queue formed outside a sweetshop and great quantities of rock [candy] were bought for grandchildren grandnieces and nephews The afternoon was free and the old people seemed to do much the same as any other group of people let loose in a seaside resort except that they did it a good deal more slowly They tried the promenade railway the slot machines in the amusement arcades the shelters and deckchairs along the front the souvenirs the ice-cream and the postcards depicting little red nosed men with drooping moustaches and fat women with large buttocks People accompa

o the tune of Oh Susanna don t you cry for me for I come from Alabama with a banjo on my knee At the centre of one of the larger groups was a white haired thin woman carrying a paper umbrella and wearing one bright red and one bright blue stocking a multicoloured dress under her coat and a Robin Hood cap A final hour or two was spent on the pier during which vast quantities of fish and chips were consumed in the pavilion On the way home the eleven

feather trembling from her head and deliberately raising the hem of her skirt to reveal

music hall

For people of upper middle and upper-class station there are informal association possibilities in their homes in social clubs, and at vacation resorts. Certain towns in southern England have concentrations of older people both as year round residents and/or vacation visitors The towns of Torquay, Bournemouth and Bath are noted as places for retired people to live At Torquay the organization known as 'The Good Companions" with 300 members, has a social center open six days a week

Another type of organization promotes friendship and informal association as a by product. This is the old people's workshop, which has been developed in a few places as a means of providing some earning opportunities to older people The workshop at High Wycombe was opened in 1955 under sponsorship of the OPWC, with its main object 'to provide the Old People of the Town and District with some occupation in pleasant surroundings and the opportunity to meet others The remuneration is and always has been of secondary importance' A small building was turned into a workshop and jobs were solicited from local business and industry In the summer of 1957 there were twelve men and about forty women working at five different jobs In addition to paying for the upkeep of the premises and for tea the earnings, when divided equally among the workers, amounted to about a shilling an hour for a 4 day week The people work in a relaxed fashion, with time out for the midday meal and for tea and conversation

ROLE OF CITIZEN

The older person in Britain is expected to retain but not to increase his civic interests A few older people maintain leadership in local community politics, though old age does not in itself give them an advantage The English believe that older people are more conservative, but this has not been proved, although it is known that more older people vote for the Conserva

grown rapidly in England in the last 10 years and may be reaching its peak at something like a membership of 20 per cent of the older people in a particular community Limits are set by the fact that people under 70 do not join such clubs readily, that people who are homebound cannot get to club meetings, that men do not join as readily as women, and that middle class persons are not so likely to join of bringing older people together to enjoy friendly association Related activities usually sponsored by old people s welfare committees, are holiday tours luncheon clubs and visiting committees The luncheon club seems to be a British invention mainly found in London or other metropolitan areas For example Hammersmith has three luncheon clubs frequented mainly by men, and serving an average of 200

TABLE 20*

RELATIONS WITH FRIENDS GREAT BRITAIN
(Per Cent)

RELATIONS WITH FRIENDS	MEN (65 AND OVER)		WOMEN (60 AND OVER)	
	Married	Widowed and Single	Married	Widowed and Single
At least one regularly visited or visiting in the home†	20	17	25	44
At least one regularly met outside the home†	44	66	14	5
None seen regularly	36	17	61	51
No	(41)	(23)	(57)	(82)

* Source P Townsend *The Family Life of Old People* (London Routledge & Kegan Paul 1957)
† At least once a month on the average

ROLE OF FRIEND OR INFORMAL GROUP MEMBER

Townsend (1957) studied older people in Bethnal Green a borough of London occupied mainly by manual workers He found that more than half the women did not visit or receive visitors from a friend as often as once a month Men were better off as is shown in Table 20 Some made friends through old people s clubs and some through the churches In this sample 72 per cent said that they were not lonely 22 per cent that they were sometimes lonely, and 5 per cent, that they were very lonely Ten per cent had three or less social contacts a day on the average, that is they saw three or less people in a customary or prearranged way at home or outside

As is the case in other Western countries the old people's club is mainly a way people a day Elderly men frequent the public parks and in bad weather they are likely to congregate in the reading room of the local library

A description given by Townsend (1957) of a one day outing of old people from Bethnal Green illustrates the type of informal group activity that appeals to a large number of working class people

About 400 old people from Bethnal Green went in 11 coaches to Brighton for a day The day was grey and cold Everyone appeared to be early One woman of seventy five had been ill the day before and had passed a sleepless night This did not prevent her coming on the outing En route the coaches hummed with talk large and small At Brighton the 400 made their way in slow moving groups to the end of the central pier where they were to have lunch in one of the large showy pavilions Bystanders were told We re from good old Bethnal Green There was much teasing and flirting mutual sympathising over infirmity and health

The churches themselves are much used as meeting places for old people's clubs, and many clergymen have active relations with a club, but very few churches explicitly sponsor programs for older people One exception to this rule was noted in Hammersmith, where the Baptist church makes a definite effort to attract older people who are not in other churches There are some religious radio services rather popular with older people

ROLE OF USER OF LEISURE TIME

While the British rather expect a man to retire from his work at about 65, there is no clearly defined role for the older person as a user of leisure time The upper class person has been more or less leisured all his adult life and is expected to go on fairly much as in the past The working class man is expected to be tired and to be happy with little or nothing to do For the middle-class man the expectations are even less clear Women of the working class or the middle class are expected to go on keeping house much as usual

Among manual workers there is a tendency to continue the use of their skills in such a way as to earn a small amount of money Often a man will take his tools to his own home and perhaps set up something in his garden For example he may raise small animals or birds for sale, or a shoemaker may continue to do a small amount of shoe repair work

Hobbies are acceptable, and training in handicrafts is generally available But relatively few men start something new along this line as they grow older Most women have handwork to do What people over 70 do with their time in the London borough of Hammersmith is reported in Tables 23 and 24 Reading and listening to the radio are most prevalent for the men, and these plus playing cards and doing handwork are characteristic of the women When they leave their homes, the women spend most of their time in public

TABLE 23*

USE OF TIME BY PEOPLE OVER 70 IN HAMMERSMITH 1953

(Per Cent)

Activity	Men (N=31)	Women (N=69)
Reading	29	59
Listening to radio	27	53
Playing cards	3	14
Gardening or tending window boxes	12	11
Keeping pets	12	11
Odd jobs about home	4	0
Handwork or hobbies	2	28
Watching television	0	2

* Source Kathleen M Slack, *Over Seventy* (London National Council of Social Service 1954)

TABLE 24*

PLACES VISITED BY PEOPLE OVER 70 IN HAMMERSMITH 1953

(Per Cent)

Place Visited	Regularly		Occasionally	
	Men (N=31)	Women (N=69)	Men (N=31)	Women (N=69)
Park or public garden	8	8	5	9
Church	1	11	6	11
Tavern (public house)	3	2	7	1
Cinema	0	4	5	14
Theater	1	1	2	5
Sports old time dancing	2	2	0	0
Public lecture	0	1	1	0

* Source Kathleen M Slack *Over Seventy* (London National Council of Social Service 1954)

tive party In a study of voting behavior in a mixed district in Bristol, mainly residential, Milne and Mackenzie (1954) came to the conclusion that "the Conservatives draw their solid support from women, the middle class, and older people" Within a given social class the older people had more of a tendency than the younger to vote Conservative A public opinion survey made in 1951 in Birmingham gave the results shown in Table 21, indicating that older people are more likely to call themselves "Conservatives" But there is no direct evidence that present-day older people have changed their political views in the moderate direction as they have grown older

There is a certain amount of political activity by the Federation of Old Age Pensioners This organization sponsors a number of old people's clubs and has a political program aimed at getting a standard old age pension of £3 a week Leaders are themselves elderly people, generally thought to have a leaning toward the Labour party

ROLE OF CHURCH MEMBER

Not more than half of the adults in Britain attend church, and, as shown in the Birmingham sample reported in Table 22, there is not much change with age Those older people who do attend church sometimes find leadership roles available to them, and they often assume useful activity in carrying on the program of the church

TABLE 21*

POLITICAL SELF REPORTS IN RELATION TO AGE IN THE BIRMINGHAM AREA

(Per Cent)

Political Preference	Age			
	16 29	30–44	45 59	60 and Over
Conservative	30	38	41	50
Liberal	7	4	7	8
Labour	36	37	27	18
Doubtful	11	11	10	9
None or no answer	16	10	14	14

* Source Unpublished data from Mark Abrams research director London Press Exchange

TABLE 22*

CHURCH ATTENDANCE IN RELATION TO AGE IN THE BIRMINGHAM AREA

Attends Church or Chapel	Age			
	16 29	30 44	45 59	60 and Over
Regularly	15	13	14	19
Occasionally	30	32	33	33
Never or rarely	55	55	53	48

* Source Unpublished data from Mark Abrams research director London Press Exchange

The churches themselves are much used as meeting places for old people's clubs, and many clergymen have active relations with a club, but very few churches explicitly sponsor programs for older people One exception to this rule was noted in Hammersmith, where the Baptist church makes a definite effort to attract older people who are not in other churches There are some religious radio services rather popular with older people

ROLE OF USER OF LEISURE TIME

While the British rather expect a man to retire from his work at about 65, there is no clearly defined role for the older person as a user of leisure time The upper class person has been more or less leisured all his adult life and is expected to go on fairly much as in the past The working class man is expected to be tired and to be happy with little or nothing to do For the middle class man the expectations are even less clear Women of the working class or the middle class are expected to go on keeping house much as usual

Among manual workers there is a tendency to continue the use of their skills in such a way as to earn a small amount of money Often a man will take his tools to his own home and perhaps set up something in his garden For example, he may raise small animals or birds for sale, or a shoemaker may continue to do a small amount of shoe repair work

Hobbies are acceptable, and training in handicrafts is generally available But relatively few men start something new along this line as they grow older Most women have handwork to do What people over 70 do with their time in the London borough of Hammersmith is reported in Tables 23 and 24 Reading and listening to the radio are most prevalent for the men, and these plus playing cards and doing handwork are characteristic of the women When they leave their homes, the women spend most of their time in public

TABLE 23*

USE OF TIME BY PEOPLE OVER 70 IN HAMMERSMITH, 1953

(Per Cent)

Activity	Men (N=31)	Women (N=69)
Reading	29	59
Listening to radio	27	53
Playing cards	3	14
Gardening or tending window boxes	12	11
Keeping pets	12	11
Odd jobs about home	4	0
Handwork or hobbies	2	28
Watching television	0	2

* Source Kathleen M Slack *Over Seventy* (London National Council of Social Service 1954)

TABLE 24*

PLACES VISITED BY PEOPLE OVER 70 IN HAMMERSMITH 1953

(Per Cent)

Place Visited	Regularly		Occasionally	
	Men (N=31)	Women (N=69)	Men (N=31)	Women (N=69)
Park or public garden	8	8	5	9
Church	1	11	6	11
Tavern (public house)	3	2	7	1
Cinema	0	4	5	14
Theater	1	1	2	5
Sports old time dancing	2	2	0	0
Public lecture	0	1	1	0

* Source Kathleen M Slack, *Over Seventy* (London National Council of Social Service 1954)

parks or at church, while the men substitute a tavern for church. These tables refer to working-class people.

When the leisure activities and interests of older people are compared with those of younger people, it develops that older people generally tend to narrow their interests and particularly to spend less time and do fewer things away from home. Tables 25 and 26 show how the reading interests of older people tend to become constricted The reduction in reading among older people may be partically due to their having less education than the present generation of younger people.

ROLE OF STUDENT

Older people are welcome in adult classes, but they do not attend in large numbers. A study of the students in adult-education classes in the Manchester area in 1947–49 showed that the proportion of

TABLE 25*

NEWSPAPER TOPICS OF MOST INTEREST TO ADULTS IN THE BIRMINGHAM AREA BY AGE

(Per Cent)

Topic	Age			
	16–29	30–44	45–59	60 and Over
Local news	59	65	73	61
Party politics	32	52	55	44
United Nations and cold war	32	50	54	43
Cartoons and comic strips	54	48	39	32
Cooking and running the home	35	43	40	40
Football	41	40	44	27
Trade and employment	31	43	47	29
Women's fashions	42	40	32	22
Films and film stars	50	36	26	12
Birds	33	30	29	21
Dance music	31	19	10	6
Racing	17	17	19	12
Concert music	16	17	18	17

* Source Unpublished data from Mark Abrams, research director London Press Exchange

TABLE 26*

AVERAGE NUMBER OF PUBLICATIONS "LOOKED AT" PER ADULT IN THE BIRMINGHAM AREA, 3 MONTHS, 1956

No. and Nature of Publications	Age				
	16–24	25–34	35–44	45–64	65 and Over
8 national dailies	1.56	1.53	1.40	1.45	1.19
10 national Sunday papers	2.43	2.39	2.36	2.20	1.71
17 general weeklies	3.25	2.74	2.45	2.21	1.48
19 women's weeklies	1.61	1.35	1.26	1.12	0.87
9 general monthlies	0.76	0.72	0.68	0.60	0.35
17 women's monthlies	1.10	0.92	0.90	0.89	0.55

* Source Unpublished data from Mark Abrams, research director, London Press Exchange

people over 50 ranged from 12 to 32 per cent, as is shown in Table 27 Another study of a national sample of people showed that 9 per cent of the people aged 45–59 had attended within the preceding week a class or society or club or political meeting This percentage decreased with age

At present the adult-education authorities are experimenting with groups to discuss problems of retirement The National Old People's Welfare Council has established a group of people to study the matter of preparation for retirement, and a movement of considerable importance may be getting under way

TABLE 27*

STUDENTS IN ADULT EDUCATION CLASSES IN MANCHESTER DISTRICT BY AGE 1947–49

(Per Cent)

Subject	Age		
	Under 30	30–49	50 and Over
International affairs	25	49	26
History	13	55	32
Sociology and social philosophy	21	52	27
Literature	15	53	32
Appreciation of music	41	47	12
Psychology	47	37	16
Biology	31	52	17

* Source W E Styler *Who Were the Student* ? (London National Institute of Adult Education, 1950)

G France

France presents a marked contrast to the other countries included in this survey Although France has the greatest proportion of older people in the population, there seems to be less feeling that old age is a problem than one finds in most other countries Perhaps this is due to the combination of a relatively large rural population and to the strength of the French family

Nevertheless some people do observe evidence that old age may be both a personal and a financial problem Tréanton (1957) studied a sample of former wage-earners in Paris who had commenced to draw their old age pension during the previous year and found that 32 per cent said that they felt 'isolated" A study of a national sample of people over 65 showed that 25 per cent were living alone, and 32 per cent of Tréanton's Paris sample were living alone. There was a considerable overlapping between the group who lived alone and those who said that they felt "isolated"

Old age brings economic distress to some 30 per cent of older people, if we may so interpret the finding of the 1949 national survey of the Institut Nationale de la Statistique (1950), in which the interviewers rated the standard of living of 7 per cent of the old people as "miserable" and 26 per cent as 'difficult" The old people rated themselves as 6 per cent "miserable" and 37 per cent in "difficult" condition Of those who were in "miserable" circumstances, 76 per cent had no savings and 7 per cent had used their savings during the year Of those in "difficult" circumstances, 58 per cent had no savings and 24 per cent had used their savings during the year

It is probably reasonably accurate to say that there is as much financial need among older people in France as in other countries Although there is a general old age pension its purchasing power has been reduced by inflation in spite of periodic increases in the pension rate

France has the lowest retirement age of all the Western nations Sixty years is generally regarded as an appropriate retirement age, and the old age pension becomes available at that age However, the pension is substantially larger for those who retire at a later age and, according to a survey made in 1956 43 per cent of the men aged 65–69 were still working full time and 21 per cent of those aged 70–79 were employed Most of these people were farmers or other self-employed people as can be seen in Table 28 Some of those ostensibly retired worked part time in a kind of "black" occupation that allowed them to earn a little money while they still drew their pensions

Retirement means a diminution of social participation, especially in the cities. Tréanton's subjects were likely to say, "I have good friends at the factory, but you know how it is in the city, we all live distant from one another. When I quit working, I quit seeing them." Others complained that the reduction of income caused them to lose their friends, because they could no longer afford to pay for the little things required for sociability.

as important ones in assisting people without depriving them of their individual initiative.

In Paris alone there are perhaps five hundred local associations giving assistance to the aged, most of them church related. The national associations with an interest in the aged appear nearly all to be church related, with the exception of several associations of retired workers, such as journalists, musicians, and actors.

TABLE 28*

OLDER WORKERS IN FRANCE BY OCCUPATION, 1956

Occupation	Men		Women	
	No. Aged 65 and Over (in Thousands)	Percentage Following Principal Occupation	No. Aged 65 and Over (in Thousands)	Percentage Following Principal Occupation
Farmowners	508	42	652	14
Farm laborers	140	20	124	3
Owners of business and industry	302	40	352	26
Professional workers and managers of business and industry	202	21	82	7
Clerical workers	148	12	122	3
Manual workers	482	18	376	13
Artists, clergy, army, police	70	17	4	50
Domestic service	50	32	366	16
Never employed	18		949	
Total	1920	28	3026	10

* Source: Institut National de la Statistique et des Études Économiques, A Sampling Study of the Economic Situation of Aged Persons, *Bulletin mensuel de statistique*, N.S. Suppl. juillet-septembre (Paris: Presses Universitaires de France, 1950).

There are a number of associations for assistance to the aged in French cities, though not nearly so many as there are of old people's welfare committees in England. These associations generally look to the welfare of aged people in economic need or in need of medical assistance. The leaders of these associations, and the social workers who work in the privately supported social agencies, believe that the government should refrain from doing much more than providing the economic base for a reasonable standard of living and that church and other private social agencies should work to preserve the autonomy of the individual. They regard their roles

The Conference de Saint Vincent de Paul, a men's organization, pays special attention to work with old people. There are several hundred local branches in the Paris area alone.

The Petits Frères des Pauvres, a laymen's organization, works systematically for the aged, providing meals, organizing holiday excursions, etc.

The Dames de Charite, with perhaps 100,000 local groups in France, is an organization principally of middle-class women which assists the needy aged with visits and material aid.

The Association Louise de Marillac, consisting of young working women, is affili

ated with the Dames de Charité There are 120 groups in the Paris region, with 4000 members

The Filles de Charite is an order of nuns which gives guidance to church women's organizations in their work with the aged

The organizations listed above are all Roman Catholic but in a list of forty five organizations which work for the aged in Paris and its surroundings, there are a number of non Catholic groups, including the Delegation Generale des Diaconats Reformes the Ligue Universelle du Bien Public, and the Societe Philanthropique

The writer s impression is that practically all the work done on behalf of older people in France is regarded as welfare work and is aimed at people in material need Thus the problems of economic support and of health and housing are met by welfare organizations private or public The problem of ego support is recognized but very little is done explicitly about it especially for people not in financial need Indeed France with her unique type of individualism may conclude that people can only be autonomous in old age if they are pretty much left to themselves and their families

ROLE OF CLUB OR ASSOCIATION MEMBER

The role of club or association member is fairly common in France and it is an acceptable role for older people The older people engage in clubs of mixed ages for example there are many local lawn bowling groups which consist mainly of middle aged and older men

Often the older man drops out of a club because his pension does not permit him to pay the costs of such participation Still Tréanton (1957) in his study of newly retired older people in Paris found that 25 per cent of them belonged to associations. He included church societies but not church membership itself as an associational membership In his sample there were a number of people who had formerly belonged to associations but had dropped out.

Associations of fishermen are found with special frequency in small cities and villages

There is considerable difference between the sexes with respect to club membership, the French women generally not belonging except to church societies

Clubs for older people seem to be unthought of by French social workers When the writer asked about them a social worker said, "Old people do not like to be with old people Anyway, the Frenchman is an individualist and does not care to have a club thrust on him"

ROLE OF FRIEND OR INFORMAL GROUP MEMBER

Recognizing that there is a problem of loneliness for older people, social workers have experimented with social centers where people can come for companionship This has been done in Paris and in some provincial cities The rooms tend to be used in bad weather, but there is no positive program attached to them Often they are used for the serving of meals to needy old people In Lyon there are some twenty such rooms, each with space for about fifty people After lunch at noon, the rooms are kept open as social centers. Public funds may be used by a municipality for such a foyer de vieillards"

Vacation tours and vacation periods are organized by welfare organizations, often using the facilities of a children's camp at times when the children are not there There is in Paris an organization known as Vacances des Personnes Agées which specializes in arranging excursions for older people.

Middle-class older people are likely to keep their friendship relations within their homes and one may find cliques of men and women who play cards together

Middle-class women whether married or widowed are not likely to go away from home very often It would be almost unthinkable for an elderly French widow to go on a bus trip with other elderly women to the Alps, for example But this would

be regarded as quite a natural thing for Scandinavian women of similar social status

Elderly French men are likely to have a favorite *bistro* where they meet their friends and talk and read the papers When such a man cannot go any more because of poor health or lack of money, life is hardly worth living for him

ROLE OF CITIZEN

The Frenchman has a passion for party politics His formal and informal associations are related to his politics He sees into a Federation Nationale des Associations des Vieux de France et des Territoires Associés At present this organization is not politically powerful

ROLE OF CHURCH MEMBER

As can be seen in Tables 29 and 30, there is a slight tendency for older people to be more religious than middle-aged ones Women are much more often devout in their religion than are men There is not much opportunity for older people to take leadership roles

TABLE 29*

RELIGIOUS OBSERVANCE IN FRANCE BY AGE, 1952

(Per Cent)

Age Group	Devout†		Nominal‡		No Visible Practice§		No Practice	
	Men	Women	Men	Women	Men	Women	Men	Women
20–34	25	37	27	40	12	12	36	11
35–49	25	44	27	30	13	13	35	13
50–64	22	48	24	26	15	18	39	8
65 and over	28	52	25	21	13	19	34	9
All ages	24	44	26	30	13	15	37	11

* Source La France est-elle encore catholique? *Les Français ont la parole* (Paris Presses d'Aujourd hui 1952)

† Devout = *Mass regularly confession more than once a year*

‡ Nominal = Mass only and often irregularly

§ No visible practice = Occasionally prays outside church

the basic divisions of society in political terms This continues as he grows older If *he is a trade union member, he belongs to a union with a particular political color,* and this union probably has a division for its retired members For instance, the Union des Vieux Travailleurs de France is associated with the CGT, a leftist labor organization, and has about 300 000 members who pay nominal dues and receive a monthly newspaper called *L'Écho des vieux* There are similar organizations allied to the CGT-FO (Socialist) and CFTC (Christian) unions

There is a politically neutral association of older people with a rather small membership, the local associations being banded

ROLE OF USER OF LEISURE TIME

The French are widely thought of as a leisure minded people, and *with their relatively* early age of retirement *they might* be expected to get great satisfaction from their leisure If this is true of elderly people, *it is not because they seek active* leisure pursuits The statistics from surveys indicate that the older people spend more time at home (Tables 31 and 32) more time in visiting friends, in gardening and in resting, than do the younger adults They do less traveling and take fewer vacation trips (Table 33)

Although they say they enjoy reading and listening to radio, they actually read somewhat less than younger adults One

study found that 24 per cent of older people do not read a newspaper, which is twice the size of the group of non-readers at the middle adult age.

Finally, the older French people do not feel the pressure of time as keenly as the younger ones do. It appears that they find it convenient to slow down and take life more easily than they did during middle age (Table 34).

TABLE 30*

RELIGIOUS BELIEFS AND PRACTICES IN FRANCE, BY AGE, 1948

Age Group	Believe in God	Believe in Immortality of the Soul	Attended Church Last Sunday or Sunday Before
21–29	62	55	35
30–49	67	59	37
50–64	70	61	41
65 and over	71	62	39

* Source: This table and Tables 31–34 are taken from various issues of *Sondages: Revue française de l'opinion publique*, 1948–53.

ROLE OF STUDENT

There is very little adult education in France in the English or Scandinavian or American sense of the term. It would be unthinkable in France for an older person to "take a course" in something. Trade-union educational activity is directed toward the younger workers. Educational preparation for retirement is not regarded as holding much promise in France.

TABLE 31*

"WHAT DID YOU DO ON EASTER?"

(Per Cent)

Age Group	Church in Morning	Church in Afternoon	Amusement	Rest or Work
20–34	35	7	54	4
35–49	35	9	51	5
50–64	34	7	54	5
65 and over	38	14	43	5

* Source: *Sondages: Revue française de l'opinion publique*, 1949.

TABLE 32*

"WHAT DID YOU DO ON SUNDAY, JULY 11, 1948?"

(Per Cent)

Activity	Age Group			
	20–34	35–49	50–64	65 and Over
	In the Afternoon			
Amusement away from home	38	30	28	25
Sport in the open air	26	24	16	12
Made or received visits	11	11	15	19
Rested	7	9	13	15
Walked in garden	1	3	5	4
	In the Evening			
Amusement at home	33	34	42	40
Amusements away from home	29	21	14	8
Made or received visits	13	10	7	6
Rested	11	16	19	28

* Source: *Sondages: Revue française de l'opinion publique*, 1949.

TABLE 33*

"WHICH AMUSEMENT DO YOU PREFER?"

(Per Cent)

Amusement	Age Group			
	20–34	35–49	50 64	65 and Over
Reading	18	23	28	32
Radio	18	24	24	27
Plays	25	19	14	7
Receptions	14	17	17	17
Going to the country	8	9	12	11
Sport competitions	3	3	1	1
Dancing	13	4	1	0
[illegible]				
[illegible]	53	45	40	23
Often	17	21	17	14
Rarely	42	36	35	28
Never	41	43	38	58

* Source *Sondages Revue française de l opinion publique* 1949

TABLE 34*

"DO YOU FEEL THE NEED OF BEING ON TIME?"

(Per Cent)

Age Group	For Work	For Train or *Bus*	For Meeting or Appointment	Do Not Feel Such a Need	Do Not Carry a Watch	
					Men	Women
18–34	47	20	9	11	27	36
35–39	47	21	8	16	28	43
40–64	29	22	5	26	25	52
65 and over	11	22	7	48	27	39

* Source *Sondages Revue française de l opinion publique* 1953

H United States

The United States has recognized a social problem of old age only during the last two decades As recently as 50 years ago the United States was predominantly agricultural, with a lower proportion of older people than northern Europe had had in 1850 But the population aged rapidly after 1920, and urbanization came on apace, with its consequent effects upon the family structure

Almost at the same time, the American people became conscious of the financial problem of old age, of the housing problem, and of the problem of ego support A national program of social security was adopted in 1936 and, with subsequent developments, now includes the vast majority of people in a contributory old age insurance scheme Also a program of assistance to needy old people was developed in the various states during the 1930's and is used to supplement the contributory old age pension where needed

The problem of ego support or of finding meaning in the later years has had major attention both by social welfare workers and by sociologists and psychologists Typically, the American solution of this problem has been to find ways of helping older people to remain socially and mentally active It has been assumed that a person will be reasonably happy if he continues to keep active and succeeds in finding substitute activities for the things he must give up as he grows older

On the other hand, it has been found that many older people are quite content to relax their hold on life, to disengage themselves slowly from interaction with people and institutions, and to assume more and more the role of a passive on looker These people make less demands upon others for ego support, though they still need it and part of the American problem is to find out how to get ego support in its less obstrusive forms

Looking at the American scene, we can discern an emerging solution of the problem of ego support for people in the age range 60–75, when most people are active enough and healthy enough to want to maintain the level of their earlier social and intellectual life The solution consists of a slow tapering off of the work life and of the social and civic activities connected with middle age and a concomitant building up of a slower moving life with friends and others who are also growing older For this purpose people seek formal and informal activities more and more with people their own age This solution takes various forms depending on the social status of people and/or their particular personal interests and family situations

There has been more study of the roles and status of older people in the United States than in other countries Consequently we can give a more objective description of the expectations which apply to older people and of their behavior in relation to these expectations.

For a description of the expectations concerning the behavior of older people we shall rely mainly upon the "Study of Public Opinion concerning the Roles of Older People" (Havighurst and Albrecht, 1953) In this study a cross section of adults of all ages was asked to judge the desirability of each of a list of 96 activities in which older people might engage From their responses it was possible to give each of the 96 activities an "approval score," which indicated the degree to which it was considered to be desirable for older people

The specific findings of this study will be applied in the several role areas to be discussed presently In general the study showed that older people were expected to taper off slowly from the high point of middle-aged activity Their activities were regarded permissively as long as they were not too strenuous and too competitive with middle-aged people Anything which seemed to indicate social isolation and mere vegetation was strongly disapproved. The most preferred activities for older people were in the home, in the church, and in informal friendship groups and associations of older people Men were expected to be more active than women, especially in the role of citizen

ROLE OF CLUB OR ASSOCIATION MEMBER

The following "approved' activities define the accepted role

- Keeps up with clubs as much as when he was younger
- Is president or secretary of a club with membership of varying ages
- Joins an organization limited to older people
- Is a regular attendant at club meetings, but not active as a leader

Disapproved ' activities are

- Does not belong to clubs and is not interested in them.
- Visits with and joins organizations of younger people only
- Still belongs to one or two clubs but no longer attends meetings

In actual behavior there is a tendency to drop out of clubs as older persons get into the sixties Some do this because they

are tired, and others because they cannot afford the expense But there are some associations which hold their older members quite well For instance, in the small midwestern community of "Prairie City," reported in the book *Older People*, 33 per cent of the Methodist Women's Society were over 65, and 31 per cent of the Daughters of the American Revolution were over 65 One of the men's fraternal associations had 43 per cent of its members over 65 American fraternal associations are likely to retain their members in old age because they generally provide certain insurance benefits for them

In "Prairie City," 28 per cent of the people over 65 belonged to clubs and attended frequently, while another 14 per cent were only nominal members and never attended The proportion of club members varied by social class from 100 per cent of upper class men to 50 per cent of upper middle class men down to none of the men in the lowest class on a five class scale Among women, the proportions varied from 100 to 20 per cent Women were more likely to belong to clubs because many of them belonged to church women's societies, while there are few such societies for men In this study business organizations and labor unions were defined as "associations"

A survey of a sample of retired people in two Florida cities was reported by Webber (1954) He found that 54 per cent of the retired people in Orlando attended club or association meetings at least once a month, while 37 per cent of those in West Palm Beach did so Women attended meetings more than men, and people of higher status more than people of lower status The community of Orlando is a favorite place for retired people, with 13 4 per cent of its population aged 65 and over in 1950 In this community, participation in clubs and associations is probably at a maximum Nearly all the participation was in organizations for people of mixed ages, but no doubt many of these organizations actually consisted largely of older people

In a study of a national sample (strongly biased toward the middle class) Cavan and her associates (1949) found that about 35 per cent of the older men and about 40 per cent of the older women attended two or more club meetings a month

The data we have been discussing deal with participation in clubs and associations which generally are open to adults of all ages In addition, there is a lively degree of activity in old people's clubs, and it is growing rapidly, though it does not approach the degree of activity in associations of mixed ages

It is possible to make a very crude estimate of the proportion of older people belonging to old people's clubs in certain states where surveys have been made Such surveys have been made in the states of Iowa, North Carolina, and New York In Iowa there were, in 1957, 74 clubs in 44 communities with 5900 members, or about 1 5 per cent of the state's population over 65 In North Carolina 64 clubs were discovered in 1954, with about 3000 members or 1 4 per cent of the population over 65 In New York a 1957 survey showed about 24,000 older people attending old people's clubs and social centers, which is between 1 and 2 per cent of the state's population over 65 The city of Cleveland had 67 clubs in 1957, with about 3000 members Thus is about 3 per cent of the population over 65

These places have a relatively extensive development of old people's clubs Consequently, it seems reasonable to estimate that about 2 per cent of the people over 65 in the United States are members of clubs of older people, which is considerably less than the proportions in Great Britain and the Netherlands

The old people's club movement is growing rapidly in the United States For instance, four fifths of the clubs in New York State have been founded since 1950 There was a national convention of senior citizens' clubs in New Orleans in 1957, with the host club in New Orleans celebrating its tenth anniversary The 1958 meeting of these groups was held in St

Louis and moved toward forming a nation al organization

There is a tendency for old people's clubs to band together into city or regional organizations For instance, the Senior Citi [illegible]

cil of Senior Citizens Organization of Schenectady, New York, with 8 clubs and a membership of 6000

The ratio of women to men in old people's clubs seems to be generally about three to one There are a few men's clubs, mainly of middle class men

Sponsorship of old people's clubs in the United States varies a great deal from one state to another In North Carolina most of the clubs are sponsored and led by staff members of community recreation depart ments wh ch are also act [illegible]

ties the Salvation Army, churches, women's organizations, and boards of educa tion The Jewish churches have been espe cially active in establishing "Golden Age clubs A considerable group of clubs have been initiated by older people themselves and are led by members of their own age group This is most likely to be the case with clubs of middle-class membership such as the Fossils of Washington, D C the Hyde Park Seniors of Chicago the Borrowed Time Club, of Lakewood, Ohio, and the Mora (Men of Retirement Age) Club of Bethlehem Pennsylvania

While a good deal of the impetus for clubs and senior centers has come from organizations such as those mentioned above, there is now developing a movement for community councils on aging analogous to the British old people s wel fare committees Two states Massachu setts and Louisiana have laws which per mit a community to spend tax money to support such councils In Massachusetts more than a hundred councils have been formed. California and New York have a good many community councils of this sort

There is no highly organized national as sociation, though there are several small organizations of this type The American Association of Retired Persons offers a group hospital and surgical expense in surance program, plus a bimonthly maga zine, *Modern Maturity* The Senior Citi zens of America, which has been led by retired educators, publishes a magazine called *Senior Citizen* and is politically neutral There are also a number of Townsend Clubs which have continued to exist main ly as social clubs after the decline of the Townsend Movement before World War II

ROLE OF FRIEND AND INFORMAL ASSOCIATION MEMBER

The role of friend is a highly acceptable role for older people, although it is known that many older people do not make new friends easily Activities highly approved by public opinion are

- Goes out and visits with other people the same age a great deal
- Keeps up by mail or telephone or by personal visits with a large number of friends
- Spends more time than formerly in visiting friends and writing them
- Visits friends and receives visits in his (her) own home
- Spends several hours a day at club or lodge rooms with old friends

Activities disapproved are

- Goes visiting relatives or friends for long periods of time
- No longer entertains groups of friends at home
- Has lost touch with former friends
- Very seldom visits with friends though able and has some
- Lives a quiet life with no social contacts other than husband or wife

In spite of this approval of friendship activities only 7 per cent of the sample in "Prairie City" had close knit friendship clique relations, while another 18 per cent had loose group relations such as giving and receiving invitations to dinner or to parties By far the majority—71 per cent—had only scattered social contacts, such as

greetings to acquaintances at church or casual conversations with people in parks or taverns Another 4 per cent were quite isolated

To help people acquire friends or at least to enter into pleasant social relations, the major method is the social center, or senior center, usually a large room or a club-house which is open all day, with a variety of facilities for informal amusements, such as games, reading, music, arts and crafts, and usually a noontime meal service Generally, such a center is sponsored by a community group with some such name as "Senior Citizens Council"

The earliest of these centers were established shortly after World War II Pioneers were the Hodson Center in New York City and the San Francisco Senior Center A number of Jewish community agencies have established such centers, and the other churches are doing likewise with such examples as the Kundig Center (Catholic) in Detroit and the senior citizens centers sponsored by the San Francisco Council of Churches (Protestant) The United Automobile Workers in Detroit operate retired workers' centers

City recreation commissions have used fieldhouses in the public parks for social centers, and presently a few cities mainly in California and Florida are building centers expressly for the use of older people The majority of existing centers are run as social welfare ventures for the underprivileged segment of the older population Exceptions are the centers in existence or being built in the retirement communities of the South and the Southwest, which draw a group of people who range in social status from upper middle to upper working class In two of Chicago's middle class suburbs, senior citizens centers have recently been established

An example of a center which appeals to people of all socioeconomic groups is Little House, in Menlo Park, California Sponsored by Peninsula Volunteers, Inc, a women's organization, Little House has a building constructed especially for the use of older people in a public park Membership totals 1250 persons over 50, with an average age of 67 The activities are divided into basic categories economic, recreation, education, physical and mental health, and community participation

Generally speaking the people of upper and upper middle class status, if they are in good health, keep up their earlier friendship associations and make new ones by going on tours and visiting places where other people like themselves are to be found

ROLE OF CITIZEN

Civic activity is accepted as desirable for older people, though they are expected to make way in positions of leadership for the younger ones Activities approved in the "Study of Public Opinion' are

Reads political news and votes regularly
Campaigns actively for his political party
Accepts minor civic responsibility, such as membership on committees
H
In
as he has done in middle age

However, the following activities are regarded with slightly less than full approval, though not with outright disapproval

Runs for high state or national office.
Runs for a minor political office
Is an interested observer but not active in civic affairs

Apparently the public does not want older people asserting themselves as vigorously in political competition as if they were in middle age Yet it is a well known fact that men elected to state and national legislatures have little difficulty being re-elected when they are in the seventies and occasionally in the eighties Senator Theodore Francis Green of Rhode Island is at 92, the oldest man ever to serve in the United States Senate

The "Prairie City" study showed that 15 per cent of older people displayed active interest or leadership in civic affairs

while another 62 per cent voted regularly but did little else of civic consequence

Outside the political arena in the non political affairs of city and state and nation older people are likely to continue in positions of prestige well beyond the age when they retire from business. This is shown in Table 35, which gives the age distribution of the community leaders in Kansas City In all except positions of business leadership and leadership of welfare agencies, the people in their seventies were overrepresented while people in their [illegible]

these women undoubtedly draw a good deal of ego support from the attentions they receive

The opportunity to serve as leaders in civic affairs is pretty much limited to people of middle- and upper-class status It is certainly important as a means of ego support to the minority who have it Recently a number of senior service organizations have been founded to increase this opportunity Examples are the Senior League of Hartford, Connecticut, the Cleveland Senior Council, and the Cedar Rapids, Iowa, Senior Men's Bureau of the Chamber of Commerce The Cleveland Senior Council for example, was formed by some retired businessmen with the aim of putting their experience to use by the community They have helped a local college to set up a money raising campaign, and several of them were recruited to lead a pre-retirement program for one of the city's industries Two counseled a social agency on its accounting and business practices In 1957 the council had 150 members paying dues of $10 a year, with an office and a part time executive secretary

A member of the Senior Men's Bureau of the Cedar Rapids Chamber of Commerce described his feelings about his participation by saying 'Now I again have

TABLE 35*

AGE AND CIVIC LEADERSHIP IN KANSAS CITY MISSOURI BY AGE GROUPS

(Per Cent)

Civic Activity	Age Group			
	30–49	50–59	60–69	70 and Over
	Men			
Art and music patrons	18	41	25	16
Trustees of educational institutions	17	30	33	20
Directors of welfare agencies	29	38	20	13
Chamber of Commerce members	29	34	29	8
Civic promotion leaders	22	41	28	9
Governmental board members	26	39	25	10
General age distribution	55	21	15	9
	Women			
Art and music patrons	30	24	28	18
Museum leaders	11	31	25	23
Directors of welfare agencies	37	40	18	5
General age distribution	51	22	16	11

* Source Richard Coleman, *Civic Participation and Leadership* ("Preliminary Report" [Kansas City Mo. Community Studies, Inc., 1955])

the chance to pay my civic rent " Service at a less prestigeful level is given by people in senior citizens' associations, as, for example, in the following summary of the work of the Los Angeles County Senior Citizens Association by its president, Mrs Marjorie Borchardt "You visit the sick and discouraged, you sew, knit, crochet hundreds of articles for children in hospitals and orphanages, you stuff envelopes for the March of Dimes, the Cancer Society, the Tuberculosis Association, and all along with this service to others, you are taking the responsibility for better government by activity in politics "

At present there is no strong political organization of older people There was one, however, during the depression of the 1930's, when the Townsend Movement with several thousand local Townsend Clubs, became powerful enough to indorse and assist in electing a substantial portion of the members of the national Congress This movement grew out of economic distress and lost its political punch when the Congress adopted old age pension laws and when economic conditions improved But, even during the good economic conditions of the postwar period, a political program for higher payments to older people in the state of California was sponsored by the California Institute of Social Welfare and almost succeeded in winning a state election

There were some small unions of old age pensioners during the 1940 s, but they, too, are now weak or non existent The fact is that both major political parties have vied with each other in liberalizing social security programs for older people and there is not now enough economic distress among older people to give rise to a political movement In 1958, thirty two of the then forty-eight states had commissions or committees on aging, appointed by the governors or set up by the legislatures In the presidential campaign of 1956, Adlai Stevenson, the losing candidate, advocated the establishment of a government bureau for older persons (analogous to the existing Children's Bureau and the Women's Bureau) President Eisenhower has established a Federal Council on Aging composed of government officials from several departments whose work impinges upon the problem of aging

ROLE OF CHURCH MEMBER

It is generally regarded as suitable for people to become more interested in religion and more devoted to church as they grow older Activities approved in the "Study of Public Opinion" are

- Goes to church regularly
- Reads the Bible or prayer book every day
- Has become more interested in church and religion in recent years
- An active leader in church
- In general keeps up his church activities or increases them as he grows older
- Gets a great deal of comfort from religious belief and church attendance

Disapproved activities are

- Has nothing to do with church
- Has become a scoffer at formal religion as he grows older
- Never attends church but speaks of himself as a church member
- No longer feels obliged to attend church regularly

It is true that people become somewhat more interested in religion as they grow older, and their attendance at church becomes somewhat more faithful until about the age of 70 when illness and feebleness cut down their attendance At this age the proportion who listen to religious services on the radio goes up However, there is no radical change in religious habits between middle and old age

Opportunity to achieve or to retain positions of prestige in the church holds up pretty well through the sixties, but few men and women keep positions of importance into the seventies In "Prairie City," 2 per cent of the older people had leadership responsibility, and 61 per cent had frequent and active participation In the national study reported by Cavan and her colleagues (1949), about 45 per cent of

the men and 55 per cent of the women attended church once a week or oftener

The Jewish churches have been pioneers in the development of programs for the ego support of their older people, through "Golden Age" clubs and social centers. Catholic and Protestant churches have been moving slowly in the same direction. For example, in 1956 the Florida Council of Churches held nine 1 day institutes on "The Church and the Senior Citizen." Still the usual thing is to expect the regular life of the church to serve the older members. Thus in a midwestern city of 400 000, of 130 Protestant churches 5 had explicit programs for older people in 1955. The Methodist church has recently started to publish a quarterly journal called *Mature Years* for its older members.

ROLE OF USER OF LEISURE TIME

The American public expects old people to enjoy their leisure if they know how to do so. Activities approved in the "Study of Public Opinion" are

Goes to a warm climate every winter.
Goes on a trip around the world.
Goes in for some special interest, such as gardening, cabinet making, collecting, painting.
Plays games with a group of friends regularly.
Goes to the theater or movies regularly.
Reads several hours a day.
Listens to the radio several hours a day.
In general gives more time and energy to recreation than during middle age.
Very active and interested in hobbies; makes them his chief interest in life.

Disapproved activities are

Never leaves home town or neighborhood on trips or visits.
Sits in a favorite chair for hours without doing anything active.
Is content to sit and watch the world go by.
Does nothing, just sits around.

It is clear that an active use of leisure time is favored, although relaxation is permitted as long as it does not seem like vegetation. In terms of actual performance, however, very few older people live up to the expectation of active leisure participation. In the "Prairie City" study only 2 per cent were rated high on an activity scale, defined as follows

Has a variety of recreational interests and

Sixty one per cent lived a role described as follows

Has some active recreations which he carries

These people do three or four of the things mentioned plus listening to the radio and visiting with friends. Thirty per cent followed essentially passive recreations, such as radio, reading and watching the world go by with some interest. Seven per cent were vegetating.

In the "Prairie City" study the middle-class and upper class people had far greater leisure activity than the working-class group. Table 36 shows the frequency of participation in the various leisure activities by the older people of "Prairie City." The relatively simple ones of reading, radio-listening, and visiting lead the list.

In the United States there have been a number of studies of what older people would like to do with their free time, with the result that at least half of most samples say that they have no wish for further activity. Those who do indicate a desire to do other things generally suggest arts and crafts and travel, followed by a great variety of other activities. There have been a number of books written on how to carry

on a recreation program for older people, with such titles as "Fun for Older Adults" and "Recreation for the Aging"

ROLE OF STUDENT

There are no definite expectations about older people in the role of student It is known that people's performance on intelligence tests decreases slowly with age, but it is expected that older people can learn if they want to They are welcome to participate in adult education courses, but very few do so

TABLE 36*

LEISURE ACTIVITIES OF OLDER PEOPLE IN A SMALL CITY

(Per Cent)

Activity	Men	Women
Radio listening	82	82
Reading	73	71
Visiting	56	73
Gardening	51	40
Sewing crocheting etc	0	60
Taking automobile rides	42	45
Letter writing	18	45
Movies	16	31
Playing cards, etc	20	25
Clubs and lodges	11	33
Community and church work	11	31
Travel	9	14
Golf and other sport	20	4
Woodworking etc	13	0

* Source R J Havighurst and Ruth Albrecht *Older People* (New York Longmans Green & Co 1953)

However, a number of older people s organizations have educational programs For example, the Hyde Park Seniors of Chicago have a class in painting and offer a variety of instruction in handicrafts Quite a few public libraries have forum programs or discussion groups that are primarily for older people The Cleveland Public Library sponsors the 'Live Long and Like It Library Club" which was started in 1946 and now has some 700 members The Drexel Home for the Aged in Chicago is experimenting currently with two study discussion groups, one on 'World Politics,' and the other on 'Current Issues in American Life" The Los Angeles School System has a group of offerings for older people under its adult education program

In these programs the older person is a student with other old people in an ordinary educational course In contrast to this, the principal educational emphasis at present is on preparation for retirement with a number of agencies using a variety of methods with people in the age range 55–65 The most highly developed program of this sort is entitled "Aging in the Modern World' and is conducted by the Division of Gerontology of the University of Michigan The program is intended to consist of ten meetings of a small group, which might be organized by a business, a library, adult school, university extension service labor union, club, church, or community center There is a guidebook for leaders and a handbook for group members containing nine essays on the following topics which are each to be discussed in one meeting

- Aging as a Modern Social Achievement
- Middle Age New Prime of Life
- The Human Machine at Mid Life
- Aging in Earlier Cultures
- New Family Roles in Middle Age
- Curiosity Comprehension Creativeness
- The Challenge of Citizenship to Middle Life
- Participation through Organization in Middle Life
- Creating the Climate for Adult Growth

There is also a book of readings supplemental to the topics in the handbook and three films The purpose of this program is to help individuals understand themselves and their situation in life better and then to plan for their retirement [3]

A different program, emphasizing more practical preparation for retirement, has been developed by the University of Chi

[3] The guidebook the handbook and the book of readings were originally prepared by the Division of Gerontology of the University of Michigan for The Fund for Adult Education under the editorships of Clark Tibbitts and Wilma Donahue The three parts have now been published in one volume by Prentice Hall Inc, under the title *Aging in Today s Society*

cago Industrial Relations Center for use by business and industrial corporations in organizing discussion groups for their older employees Burgess *et al* (1958) studied the people who come into such groups in the companies which are using this program and concluded that the program for executives should be different from that for employees of lower middle and working class status

A number of business and industrial corporations now provide leaders for preretirement study groups using a program similar to those already described In Cleveland a recent survey found that five companies had study groups while about forty companies had a counseling program for individual workers

In Minneapolis the Hennepin County CIO Industrial Union Council offers preretirement courses to its members in the 55–65 age group In 1958 the United Automobile Workers gave preretirement courses in their summer schools.

There are two principal aims of the preretirement courses One is to give the individual assistance in taking stock of himself and –

growing older so that he becomes more able to look at his problems objectively knowing that his concerns are similar to those of other people and not signs of abnormality in himself

The role of student is most readily accepted by middle-class people who have had more experience with it than by working-class people However, the experiments with educational programs for workers seem to indicate that these people also have something to gain from student activities

III Conclusions

The purpose of this chapter has been to make a descriptive comparison of the ways in which older people get ego support in various Western countries, without evaluation of the success of people in any of these countries

We cannot say that ego support is better achieved in one country than another To make such a statement would require two things (1) much more adequate information than we now have and (2) the comparative evaluation of ego support coming from various sources For example, France and Switzerland may seem to be lacking in social machinery (clubs, social centers, etc) for ego support, but they may provide more of the traditional forms of it through the family

The goal generally agreed upon in all these countries is a considerable degree of *autonomy* for older people, in contrast to *anomie* and *apathy* Autonomy, in contemporary Western society, is gained and maintained by performing certain *self preserving* and certain *socially valuable* functions.

It is not so easy for older people to perform these functions in an urban, secular society as it was in the traditional agricultural society of western Europe Then the older person had a sort of social usefulness which is still found in the older European peasant, who looks after the domestic animals, tends the garden, repairs the hand tools and takes care of the grandchildren At the same time the elderly peasant takes care of himself This person has the autonomy of being a functioning member of a family which is an economic unit. Though bound to the family in space, he nevertheless is autonomous The old German lady who complained that she could no longer serve her family by darning their stockings because they now wore nylons was saying in effect that she *had lost* her function in the family and no longer felt that she counted Therefore she was losing her autonomy

When the old person is in danger of losing his function in the family, he tries to become autonomous by living independently, by keeping his job as long as possible, by striving to associate with younger people, and, in general, by doing things which

symbolize autonomy The problem of Western urban society is thus to help people to preserve their autonomy or even to enhance it, while at the same time acting through the state to provide economic security and protection against social isolation This is not easy to do The state is always in danger of doing too much as well as in danger of doing too little for the individual

Therefore people who are working with and for older people must understand and respect what the German Committee for the Welfare of Old People has as its motto, "Der alter Mensch ein Subjekt ist, und nicht ein Objekt," "The Old Person Is a *Subject* and Not an *Object*"—to be handled as a sack of vegetables by the employees of the state

In what ways, then, does the older person function in the various social roles outside of work and family? Does he find ways to function which enable him to preserve his autonomy?

A Club or Association Member

In all Western societies the old person's retaining of club participation is approved, but in all of them he tends to give up this participation because it costs him too much money or too much energy and because he comes to feel that he is not welcome Probably the greatest participation of older people in associations of mixed ages is found in the United States the Netherlands, France, England, and Germany, with lesser participation in Sweden Denmark, and Switzerland

In the case of participation in old people's clubs, the Netherlands and Great Britain give the greatest opportunity, followed by the United States Then come four countries which are just beginning to experiment with old people's associations Sweden, Denmark, Germany, and Switzerland Finally, France has very little club activity in old people's groups

Generally, people of lower socioeconomic status get the most help from old people's clubs, though middle class people participate to some extent in the United States, the Netherlands, Switzerland, and Sweden

Women take part more frequently than men by a ratio of about three to one in all countries except the Netherlands, where the ratio is just reversed, men being much more active in old people's clubs than women

B Friend or Informal Group Member

It is highly approved that older people should have many friends and spend much time with friends, particularly with people of their own generation However, older people tend to constrict their social life space, allowing old friends to drop away without making new ones The most is done in the United States to help people retain and develop this role, partly through the existence of retirement communities in warm climates and partly through the provision of social centers for older people In the second place with respect to social facilitation of this role are Great Britain the Netherlands, and Sweden Next come Switzerland, France, Germany, and Denmark

C Provision of Facilities for Social Relations

Since the conduct of old people's clubs and social centers requires physical facilities, leadership, and money, there must be some agency or agencies to provide these things In general there are four possible types of agencies to do this They are

1 *Social welfare agencies—private and public financed* —The private agencies consist of women's organizations old people's welfare committees, and senior citizens' committees The public agencies consist of social welfare boards A problem for these agencies is to find space for their projects since they seldom have rooms or buildings of their own

2 *Community adult education and recreation associations—private and public financed* —These include YMCA's, schools, and public recreation agencies In Sweden

a special institution is the Peoples House, which maintains a building for social and educational purposes These agencies nearly always have space to offer, but often they do not have leadership to give, unless they are public agencies with a professional staff

3 *Churches*—These agencies have space but often lack trained leadership for work with older people The Jewish churches in the United States are an exception in this respect for they are generally well staffed for this kind of work

4 *Old people's organization*—These are strongest in Sweden, the Netherlands, and Great Britain. They tend to be led by older people with experience in political leadership and have a national organization Finance is their main problem. In the United States there are a few old people's organizations with middle-class leadership and mainly middle-class composition They are organized on a local basis

D Role of Citizen

Participating as citizens in political and community life, old people are expected to remain interested and to show little diminution of activity However, functioning in this role does not give much ego support to the average person because he has never been very active in it, and he cannot now increase his activity Some upper-class and middle-class people have secured pres [illegible]

time when their occupational role loses its value to them.

As members of a political pressure group old people may get a considerable amount of ego support, feeling that they are working effectively on their own behalf, while a minority of them also get the prestige of leadership This source of ego support is greatest in Sweden Great Britain and the Netherlands. It has a medium value in Denmark and Germany and little importance in France, Switzerland, and the United States

E Role of Church Member

The role of church member is generally regarded as an especially favorable one for older people both because it gives them a chance at social participation and because it gives them spiritual support. However, there is relatively little opportunity for older people to serve as church leaders There is some tendency for the urban churches in all Western countries to recognize the social problem of aging and to undertake to increase the ego support for older people This tendency is most pronounced in the Netherlands Switzerland, Denmark, and the United States occupy a middle position in this respect, while Sweden, France, Great Britain, and Germany show the least evidence of it

F User of Leisure Time

In all the countries an active, creative use of leisure time by older people is respected and even admired, but it is not expected that many older people will accomplish this Rather it is expected that older people will be happy if they can "take things easy" and engage in relatively passive leisure activities for which they have always had a preference but not always enough free time Greater activity in leisure pursuits is to some extent expected and found in the United States, Great Britain, Sweden, Germany, and Denmark, possibly in that order More passive use of leisure is found and expected in France, the Netherlands, and Switzerland

Most older people become less and less active, physically, socially, and mentally, and this is reflected in their use of leisure The statistical studies of leisure time pursuits show that in all countries people increase their preferences for reading, radio-listening visiting, and handwork for women They do not go in for demanding types of intellectual activity In Switzerland, Germany, the Netherlands, and Denmark there seems to be a strong preference for gardening, raising small animals, and taking walks Travel is mentioned as a de-

sirable thing especially by Swedes and Germans, though American middle class older people probably actually do more traveling than any other old age group

The evidence about the possibilities of older people developing new interests in handicrafts and hobbies is not clear Some studies of preferences indicate that many people would like to learn new things of this sort, but in practice the projects for teaching handicrafts and for developing hobby interests seem to have been success ful only in a limited group of middle class people

The possibility of gaining ego support through a more stimulating use of leisure appears to be good and is being explored vigorously in Great Britain and the United States especially

G Role of Student

Although the role of student is accepted in public opinion as a good one for older people, it is not really expected, nor is it explicitly provided for in the European countries Older people are welcome in adult education courses, but few of them appear In the United States there is a little more effort to develop study and dis cussion groups and workshop training for older people, but this could not be said to be well established On the other hand there is in the United States a growing movement for study courses and discussion groups aimed at helping people in late middle age to prepare better for their old age

H Social Status and Ego Support

In all the countries studied it appears, in regard to social status and ego support, that

1 Upper and upper middle class people have more opportunity for ego support in their later years and are more in need of it They are more autonomous in an urban society than are lower status people, and they preserve their autonomy better

2 Working class people are the targets of major efforts by private and public social agencies in programs for ego support.

3 Rural people have the least need of programs of ego support, because they have families and functions that provide them with a substantial measure of it.

Autonomy appears to be enhanced under the following conditions (*a*) a person re tains important functions of middle age (this is common in rural societies and oc curs when an urban person retains his role as worker), (*b*) a person is a member of a family in which he has a significant func tion (this is more common in rural than in urban societies), (*c*) a person has high economic status (this enables him to do autonomy preserving things, many of which cost money), and (*d*) a person has op portunity for free social interaction with a variety of people under a variety of cir cumstances (this occurs most frequently for upper class and upper middle-class people)

I Principles of Ego-Support Policy

It appears that a social policy aimed at ego support will do the following things in a modern society (1) increase opportuni ties for free social interaction through en couraging the efforts of older people to function in the roles of club member, friend, and church member (2) help older people to retain their functioning in the roles of worker, citizen, and church mem ber and (3) aid older people in preserving or discovering active and stimulating leisure activities, partly through education

REFERENCES AND BIBLIOGRAPHY

Aging A monthly news bulletin issued by the United States Department of Health, Educa tion, and Welfare

BURGESS E W, COREY, L G, PINEO P C, and THORNBURY, R T 1958 Occupational differences in attitudes toward aging and re tirement J Gerontol, 13, 203-6

CAVAN, RUTH S, BURGESS, E W, HAVIG HURST, R J, and GOLDHAMER, H 1949 Per

sonal adjustment in old age Chicago Science Research Associates

CENTRE NATIONAL DE L'ÉDUCATION SANITAIRE, DÉMOGRAPHIQUE ET SOCIALE 1952 La Sante de l homme (Monthly Publication No 75) December Special issue on problems of aging Lyon The Centre

DIEDRICH, J 1955 *Report of a survey of older people 1951–52* Amsterdam Bureau voor Marktanalyse en Sociografisch Onderzoek.

FRANCE INSTITUT NATIONAL DE LA STATISTI

sons Bull. hebdomadaire de statistique, No 431 (August 4)

FRIEDEBURG L. VON 1955 Altersbild und Altersvorsorge der Arbeiter und Angestell ten. Frankfurt Forschungsbericht, Inst fur Sozialforschung, Universitat.

GREAT BRITAIN NATIONAL OLD PEOPLE S WEL FARE COUNCIL 1955 Old people's clubs London The Council

GROTH S 1954 Das Alter in Aufbruch des Daseins (Soziografisches Institut, Univer sitat, Frankfurt, Neue Druck und Ver lagsgesellschaft) Frankfurt

HAVIGHURST, R. J, and ALBRECHT RUTH 1953 *Older people* New York Longmans Green & Co.

INSTITUT FRANÇAIS D OPINION PUBLIQUE. Son dages revue française de l opinion publique Paris

INSTITUTE FOR RESEARCH IN SOCIAL SCIENCE 1956a A manual of organization clubs for senior citizens. Chapel Hill University of North Carolina.

——— 19 6b Recreation for the aging in North Carolina. Chapel Hill University of North Carolina.

KARRENBERG F and BISMARCK, K. VON 1956 Das Lebensrecht *des alter* Menschen (Kirch im Volk," No 20) Stuttgart Kreuz Verlag

LENHARTZ, L 1958 Altersprobleme des Selb standigen grosstadtischen Mittelstandes Stuttgart Ferdinand Enke Verlag

MILNE, R. S, and MACKENZIE, H C 1954 Straight fight a study of voting behavior *in the constituency of Bristol North East at* the general election of 1951 London Han sard Society

NEULOH, O 1956–57 Die Situation der Alter Bergleute (Progress report in files of the Sociografic Institute at Frankfurt)

NEW YORK STATE JOINT LEGISLATIVE COM MITTEE ON PROBLEMS OF THE AGING 1957 Brightening the senior years Albany The Committee

REIGROTZKI, E 1956 Soziale Verflechtungen in

stituts fur Sozialwissenschaften Köln) Tu bingen J C B Mohr

SLACK, KATHLEEN M 1954 Over seventy Lon don National Council of Social Service

TARTLER, R. 1957 Das Alter in der modernen Gesellschaft Stuttgart Ferdinand Enke

TOWNSEND, P 1957 The family life of old people London Routledge & Kegan Paul

TREANTON, J R 1957 L'adaptation des person nes agées a la vie urbaine *In Proceedings of the* Fourth Congress, International Associa tion of Gerontology, Merano, Italy, 3, 518–26 Fidenza Tipografia Tito Mattioli

UNION SOCIALE Journal of the Union Nationale Interfederale des Œuvres Privées Sanitaires et Sociales Paris (This journal of the union of *private welfare* societies has frequent ar ticles dealing with problems of *aging*)

VAN ZONNEVELD, R. J 1960 Health conditions of the aged in the Netherlands

WEBBER, I L. 1954 The organized social life of the retired two Florida communities Am J Sociology, 59, 340–46

X

Research on Aging[1]

JOHN E. ANDERSON

I INTRODUCTION

One of the striking characteristics of aging is its obviousness to the ordinary, casual observer In this respect it is like growth However much we need science to supply information as to process and underlying causes, we do not need science to tell us that children grow or that people age, as both happen before our very eyes Moreover it is apparent that some persons grow old more rapidly than their peers while others preserve their capacities until late ages But, ultimately, if they live long enough all persons require care in greater or less degree In the sense both of progressive change and of the need for care the problems of the aging are universal and are encountered in every society But some societies, more particularly primitive ones place less emphasis upon time and upon age than do the more industrialized societies in which people live by the clock and divide themselves by age categories

In visiting various countries, one cannot but be impressed with the fact that the same human problems appear in culture after culture, more particularly in highly organized and complex industrial cultures and are met in one way or another On examining the methods of meeting the problems, similarities also appear regardless of the names they are called or the social institutions in which they find a place So also with the science and practice of gerontology

[1] In reading this chapter note that this presentation is neither a complete summary nor a de [illegible]

ber of centers and talked with various gove[illegible] tal and university people Involved also was some correspondence to clear up points

This chapter was intended to cover designed research projects within psychology sociology, and other social sciences that relate to the problem of [illegible] and clinical studies were [illegible] were the [illegible] ts since [illegible] volume [illegible] ich seek [illegible] e defined data upon samples of older peop[illegible]

fashion by interview questionnaire observation [illegible] chapter seeks to give the Ameri[illegible] d variety [illegible] some im pression of the way in which research is organized in terms of the available facilities For the more specific results the reader should await the appearance of the scientific papers based upon the investigations which are described

May I express my cordial thanks to the many persons in Europe who helped me from time to time in gathering material for this report and my [illegible] that I cannot mention them all Mi[illegible] [illegible] stair Heron Torsten Husén James Inglis [illegible] Pacaud Jean René Tréanton Klaus Riegel H Thomae Henning Friis and R J van Zonneveld, all of whom either gave me substantial time or sent me substantial material

In any survey of ongoing or projected research within a number of countries, some account must be taken of the position attained by scientific endeavor in those countries. This is especially true of the psychological and social sciences, in which tradition favors a speculative and theoretical approach while modern emphasis is upon an empirical or experimental approach. In spite of much interchange of method and results, the scientists within each country work toward the solution of their own problems in their own way. At an international congress a visiting scientist is impressed by the scientific sophistication of some countries as compared with the more primitive research done in others. Each group within a culture area seems to move through its own historical development as it goes from the successful solution of simpler problems to the attack on more complex ones.

In early research on aging, emphasis went to the biological and medical aspects. The former arises as an interest area because students of lower organisms with short life-cycles see aging as characteristic of the entire life-cycle and seek to understand it as a significant part of the life process. Because medicine is intrusted with the direct care of old people, physicians become interested in what happens to aging patients. And the prolongation of life by conquering disease and disability changes medicine itself and thus forces concern with aging and particularly with chronic illnesses. Hence interest in the biology of aging and the medical care of older people antedates interest in psychological and social care and seems to be farther along in its development in most countries, including our own.

A The Evolution of Behavioral and Social Sciences

As background for the approach to psychosocial gerontology, we should consider three interrelated phenomena in the history of scientific thinking.

MOVEMENT TOWARD EMPIRICISM

The first dichotomy contrasts philosophizing about human behavior with an empirical approach through observation and experiment. In the history of human thinking mankind took a very long time to become empirical and to observe natural phenomena systematically. It took still longer to arrive at the point at which conditions or experimental and control techniques were deliberately set up to secure data. This development occurred first in the physical and natural sciences and later in the behavioral and social sciences.

In some European cultures the behavioral and social sciences are still dominated by earlier conceptions with emphasis on philosophy and theory. Moreover, among scholars there is a wide range of persons with divergent interests. Some prefer to stay in an ivory tower and manipulate symbols, while others go out into the world of objects and relations and secure basic facts upon which to build their conceptions. Often there is a tradition, especially within universities, that understanding is improved by being remote from life rather than immersed in it. Continental Europe seems still to have much discussion on the theoretical and philosophical level, especially among university men. This is more apparent in sociology than in psychology, with its stronger empirical tradition. In Great Britain and the United States, as contrasted with the Continent, the empirical tradition with regard to both psychological and social problems is strong.

TAXONOMY VERSUS EXPLANATION

The second dichotomy relates to the cataloguing and describing of changes with age versus the explanation of change by an analysis of the underlying factors responsible for it. It has long been noted that in those sciences which concern themselves with living systems, beginning efforts toward understanding involve classification and description of the many variants that occur among individuals and species. Grad

ually, these observations are supplemented with specifically designed experiments set up to test particular hypotheses More understanding emerges At some point in history the experimental approach almost replaces the taxonomic approach But in a later stage naturalistic and ecological studies reappear, and thereafter science moves forward with a parallel interest in classification and in experiment

In the field of psychological and social gerontology, this dichotomy also emerges We deal with an aging life system with all its internal and external relations We have a large concern with documenting the changes in this system as they occur, and we need such documentation not only for assessment purposes but also for stating the significant scientific problems From taxonomy we move on to the factors that produce change and ask why one person changes more rapidly than another, how the rate of change can be modified, and how the system can be improved

One particular aspect of taxonomy deserves special emphasis, namely, the area of social statistics about older people Every nation in our Western culture collects statistics about its people and, in doing so, breaks down the results in terms of age, sex, status, occupation etc Generally, the more industrialized the country, the more statistics It would be possible, also, I think, to show that, as science advances within a country, statistics advances also

It is obvious that, in order to secure a comprehensive view of the aging and the aged in terms of their limitations and potentials, we need a wide variety of data collected by and from many different sources We need social statistics and government reports to picture the extent of the problems put to society by the aging population We need surveys of the needs of older people classified by age, sex, and socioeconomic status and of the current practices of meeting these needs We need clinical reports and case histories as a source of exploratory material to aid in the design of investigations As social problems arise, various breakdowns of the available statistics can be made in order to bring information to bear upon current practical problems And, of course, good descriptive statistical material may be analyzed at any time after it is collected on the basis of hypotheses to arrive at scientific generalizations

But it is also clear that, in order to build a sound framework of understanding and practice, we need designed and organized research that moves in to solve specific problems and to give specific answers to the questions raised by the other methods If at a time these may seem to be in the ascendant, we still must not neglect the observational, naturalistic, or ecological methods which record the behavior of older persons in their habitats and establish the relations of their needs and actions to their environments, since these methods supplement and check all others Science moves forward by a multiple attack, methods are its tools, the outcomes are conceptualizations or generalizations that enable us not only to control and predict behavior but also to modify stimuli and situations in a desired direction to meet practical purposes

AGING PROCESS VERSUS ELDERLY PERSONS

The third dichotomy relates to the orientation of thinking and research about the understanding of the nature and process of aging as contrasted with concern about the methods of caring for aging persons once the changes have occurred

Heron (1957) has pointed out that there are two kinds of psychology in approaching the problems of older people One is the psychology of the aging process, which is concerned with understanding what is happening within the organism and in the organism's relationship to its surroundings This is science in a traditional sense The other is the psychology of the elderly person Given older people as we find them

what can we discover about them and what can we do in the practical sense to improve their lot? How can we provide them with good care? How can we motivate them to learn and how do they learn? These are very different types of problems in terms of purpose or goal

The problems of the elderly as such can be met either on the basis of practical experience or by measures which are the outcome of scientific knowledge European countries, with their old populations, have been facing the problem of aging persons for a long time On a practical level, using what might be called "social trial and error," substantial programs of care and many institutions of one type or another have been developed for older persons These have made possible the partial solutions of problems It is also clear that the advances of modern medicine are operating throughout the whole of Europe to prolong life and thus create larger problems of care The principle of retirement is likewise being more widely applied and everywhere creates the problem of how the state can deal with unproductive persons in their declining years

The prolongation of life and the cessation of productivity well in advance of death create psychological and social problems that do not arise in societies composed of younger persons And psychology and sociology as academic subjects are now directed mainly toward a young population of students and have in the past been primarily concerned with the adjustment of children, adolescents, and young adults Everywhere there arises a need for turning the attention of scientists and the new personnel they are training with n these fields to the problems of the aging process and to the care of elderly people. Once a number of investigators go to work on various problems, there emerges a substantial body of empirical data and of generalizations upon which much of the practice in dealing with the psychological and social problems of older persons can be based It is also clear that our societies, American as well as European, are committed to a research approach, because all alike are seeing the world in which they live transformed by science

B Study of Participation of Various Countries in Meetings and in Publication

In order to furnish the reader a background with which to approach the research going forward in various countries and to make some comparisons between biological and medical research and psychological and social research, various analyses were made of the number of countries participating in the Third and Fourth International Congresses of Gerontology and of the fields and areas of gerontology covered by the papers presented at the congresses and represented in the "Index to the Current Periodical Literature" in the *Journal of Gerontology* In addition, an analysis was made of the increase in the literature on gerontology over time

NUMBER OF COUNTRIES REPRESENTED AT THE INTERNATIONAL CONGRESSES

An analysis was made of the articles, abstracts, and titles published in the *Proceedings* of the Third Congress of the International Association of Gerontology in London and of the abstracts and titles published in the *Program* of the Fourth Congress of the International Association of Gerontology at Merano and Venice, Italy, by the number of countries from which those presenting material came The results are presented in Table 1

More countries were represented at the Merano conference by papers of all types than at the London conference While every country represented had papers in biological and medical research, papers in the psychological social, and economic areas were confined to fewer countries

Another analysis is presented in Table 2, which shows the order of areas of interest in terms of the number of papers which were presented from various countries For

ually, these observations are supplemented with specifically designed experiments set up to test particular hypotheses More understanding emerges At some point in history the experimental approach almost replaces the taxonomic approach But in a later stage naturalistic and ecological studies reappear, and thereafter science moves forward with a parallel interest in classification and in experiment

In the field of psychological and social gerontology, this dichotomy also emerges We deal with an aging life system with all its internal and external relations We have a large concern with documenting the changes in this system as they occur, and we need such documentation not only for assessment purposes but also for stating the significant scientific problems From taxonomy we move on to the factors that produce change and ask why one person changes more rapidly than another, how the rate of change can be modified, and how the system can be improved

One particular aspect of taxonomy deserves special emphasis, namely, the area of social statistics about older people Every nation in our Western culture collects statistics about its people and, in doing so, breaks down the results in terms of age, sex, status, occupation etc Generally, the more industrialized the country the more statistics It would be possible, also, I think, to show that, as science advances within a country, statistics advances also

It is obvious that, in order to secure a comprehensive view of the aging and the aged in terms of their limitations and potentials, we need a wide variety of data collected by and from many different sources We need social statistics and government reports to picture the extent of the problems put to society by the aging population We need surveys of the needs of older people classified by age, sex, and socioeconomic status and of the current practices of meeting these needs We need clinical reports and case histories as a source of exploratory material to aid in the design of investigations As social problems arise various breakdowns of the available statistics can be made in order to bring information to bear upon current practical problems And, of course, good descriptive statistical material may be analyzed at any time after it is collected on the basis of hypotheses to arrive at scientific generalizations

But it is also clear that, in order to build a sound framework of understanding and practice, we need designed and organized research that moves in to solve specific problems and to give specific answers to the questions raised by the other methods If at a time these may seem to be in the ascendant, we still must not neglect the observational, naturalistic, or ecological methods which record the behavior of older persons in their habitats and establish the relations of their needs and actions to their environments, since these methods supplement and check all others Science moves forward by a multiple attack, methods are its tools, the outcomes are conceptualizations or generalizations that enable us not only to control and predict behavior but also to modify stimuli and situations in a desired direction to meet practical purposes

AGING PROCESS VERSUS ELDERLY PERSONS

The third dichotomy relates to the orientation of thinking and research about the understanding of the nature and process of aging as contrasted with concern about the methods of caring for aging persons once the changes have occurred

Heron (1957) has pointed out that there are two kinds of psychology in approaching the problems of older people One is the psychology of the aging process, which is concerned with understanding what is happening within the organism and in the organism's relationship to its surroundings This is science in a traditional sense The other is the psychology of the elderly person Given older people as we find them

what can we discover about them and what can we do in the practical sense to improve their lot? How can we provide them with good care? How can we motivate them to learn and how do they learn? These are very different types of problems in terms of purpose or goal

The problems of the elderly as such can be met either on the basis of practical experience or by measures which are the outcome of scientific knowledge European countries, with their old populations, have been facing the problem of aging persons for a long time On a practical level, using what might be called "social trial and error" substantial programs of care and many institutions of one type or another have been developed for older persons These have made possible the partial solutions of problems. It is also clear that the advances of modern medicine are operating throughout the whole of Europe to prolong life and thus create larger problems of care The principle of retirement is likewise being more widely applied and everywhere creates the problem of how the state can deal with unproductive persons in their declining years

The prolongation of life and the cessation of productivity well in advance of death create psychological and social problems that do not arise in societies composed of younger persons And psychology and sociology as academic subjects are now directed mainly toward a young population of students and have in the past been primarily concerned with the adjustment of children, adolescents, and young adults Everywhere there arises a need for turning the attention of scientists and the new personnel they are training within these fields to the problems of the aging process and to the care of elderly people Once a number of investigators go to work on various problems, there emerges a substantial body of empirical data and of generalizations upon which much of the practice in dealing with the psychological and social problems of older persons can be based. It is also clear that our societies, American as well as European, are committed to a research approach, because all alike are seeing the world in which they live transformed by science

B Study of Participation of Various Countries in Meetings and in Publication

In order to furnish the reader a background with which to approach the research going forward in various countries and to make some comparisons between biological and medical research and psychological and social research, various analyses were made of the number of countries participating in the Third and Fourth International Congresses of Gerontology and of the fields and areas of gerontology covered by the papers presented at the congresses and represented in the "Index to the Current Periodical Literature" in the *Journal of Gerontology* In addition, an analysis was made of the increase in the literature on gerontology over time

NUMBER OF COUNTRIES REPRESENTED AT THE INTERNATIONAL CONGRESSES

An analysis was made of the articles, abstracts, and titles published in the *Proceedings* of the Third Congress of the International Association of Gerontology in London and of the abstracts and titles published in the *Program* of the Fourth Congress of the International Association of Gerontology at Merano and Venice, Italy, by the number of countries from which those presenting material came The results are presented in Table 1

More countries were represented at the Merano conference by papers of all types than at the London conference While every country represented had papers in biological and medical research papers in the psychological, social, and economic areas were confined to fewer countries.

Another analysis is presented in Table 2 which shows the order of areas of interest in terms of the number of papers which were presented from various countries For

all countries the contributions in the biological and medical field outnumber those in the psychological and social field. No attempt was made to correct the crude figures for size of the population or the number of scientific investigators in each country. A correction that might well be made would be one for the country in which the congress was held, as this gives local workers some advantage. However, the major point of the table is that the great bulk of psychological and social investigations are carried on in the United States and in Great Britain.

There is also some difference in the relative emphasis placed on gerontology in Europe as compared with the United States. If we group all the papers presented by countries other than the United States together, at the London conference 67 per cent and at the Merano conference 78 per cent were in the biological and medical field. The corresponding figures for the psychological and social field were 33 per cent for the London Congress and 22 per cent for the Merano Congress. But for the United States the figures for the biological and medical field were 55 per cent at the London Congress and 61 per cent at the Merano Congress as compared with 45 per cent for the psychological and social field at the London Congress and 39 per cent at the Merano Congress. This suggests that at the present time there is within the American culture, as contrasted with western European culture, somewhat more emphasis upon psychosocial gerontology.

TABLE 1

PAPERS AND NUMBER OF COUNTRIES AT THIRD AND FOURTH INTERNATIONAL CONGRESSES

Area of Interest	No of Countries	
	Third Congress (London)	Fourth Congress (Merano)
Biological and medical research	15	20
Medical care	5	14
Psychological research	4	7
Sociological research	0	3
Social care	5	8
Social statistics	4	4
Economic statistics	3	6
All psychological and social	9	13
Papers in any area	15	20

AREAS OF INTEREST AT INTERNATIONAL CONGRESSES

A breakdown was also made of the papers presented at the Third and Fourth International Congresses at London and Merano, since this gives some idea of the range and character of the present interests within the field. The results are presented in Table 3.

Approximately half the papers presented at both congresses were concerned with research in the biological and medical field When to these are added the papers on

TABLE 2

ORDER OF INTEREST IN AREAS BY COUNTRIES

Country	Biological and Medical		Psychological and Social	
	Third Congress (London)	Fourth Congress (Merano)	Third Congress (London)	Fourth Congress (Merano)
United States	49	63	41	40
United Kingdom	38	26	26	25
Italy	7	84	0	13
Netherlands	2	10	1	1
Germany.	1	9	1	4
France ...	6	8	1	2
Switzerland	4	3	3	0

medical care, about two-thirds of all papers are in the medical field Adding the psychological social, and economic divisions we find that about one third of the papers are covered Another breakdown is found in the last three items in the table which show that over half the papers at each congress are devoted to research, about one tenth to statistics and about one-third to practical problems of care either medical or social.

LANGUAGES IN WHICH ARTICLES ON GERONTOLOGY APPEAR

By an analysis of entries in the classified bibliography in the *Journal of Gerontology* for Volumes 6–12 (1951–57 inclusive) in which the system of classification remained

TABLE 3

AREAS OF INTEREST AT INTERNATIONAL CONGRESSES

Area of Interest	Third Congress (London) No	Third Congress (London) Per Cent	Fourth Congress (Merano) No	Fourth Congress (Merano) Per Cent
Biological and medical research	99	51	162	46
Medical care	21	11	87	26
Psychological research	15	8	24	7
Sociological research	0	0	9	3
Social care	41	21	36	11
Special statistics	6	3	4	1
Economic statistics	14	7	21	6
All biological and medical	120	61	249	73
All psychological, social and economic	76	39	94	27
All research	114	58	195	56
All statistics	20	10	25	7
All care	62	32	123	37

constant a study was made of the languages in which material in the psychological and social fields was published It was thought that trends might appear with time but these did not appear, except that, in Volume 6 (1951), 90 per cent of the articles are in English and only 10 per cent in other languages, whereas from Volume 7 (1952) onward approximately three-fourths of the articles are in English and one-fourth in other languages The percentages for the entire period covered are English, 78, French, 6 5, Italian 4 5, German, 3 4, and all others (Japanese, Spanish, Russian Portuguese, etc), 7 5 When this analysis was first undertaken it was hoped that it could be made by country of origin rather than by language of publication However, it soon became clear that the references did not contain enough information to make this possible Going back to the original articles was out of the question

TABLE 4

ABSTRACTS ON AGING BY PERIODS

Volume and Year	Average Total Abstracts per Year	Average No of Abstracts on Aging per Year	Percentage of Total
1 7 (1927 33)	4 04	6 29	0 14
8 14 (1934–40)	62 0	10 00	0 16
15–21 (1941–47)	4555	23 71	0 53
22 29 (1948–54)	7362	80 86	1 09

INCREASE IN SCIENTIFIC INTEREST IN AGING WITH TIME

In order to discover the nature of the changes in our interests in aging over time, an analysis was made of the proportion of entries which relate to aging in the yearly index of the *Psychological Abstracts*, which has been published since 1927 The twenty eight volumes were divided into four 7 year groups and the proportions of references to aging to the total number of abstracts were calculated for each 7 year period The results are presented in Table 4

It should be noted that, since this yearly index contains cross references to all appropriate entries, the numbers are always greater than those for the abstracts placed in the section 'Maturity and Old Age' These index figures are probably under

estimates since failure to note an entry is more likely than is overentry

Although the proportions are small, the rate of growth is rapid when compared with other areas While the absolute numbers of abstracts in the "Infant, Adolescent, and Family" area have increased during the same period, the relative number of proportion has remained unchanged (Anderson, 1956*a*) Moreover, references to aging increased about eight times, while the total number of abstracts increased one and one half times The increase is from 0 14 of 1 per cent to 1 09 per cent over a 27 year period

As an indication of the current rate of interest we obtained the percentage of papers at the two most recent large psychological meetings At the Fifteenth International Congress of Psychology, held in Brussels in 1957, of 256 communicated papers, 7, or 2 7 per cent, were concerned with the problem of aging Of these, 6 were by European and 1 by American authors This percentage is not much different from that at the 1957 meeting of the American Psychological Association, at which, of 542 contributed papers, 13 (or 2 4 per cent) dealt specifically with problems of aging

In connection with the data on the articles on psychology, the question might well be raised as to what this proportion should be under ideal conditions In my study of the proportion of references in *Psychological Abstracts* devoted to various scientific fields over a period of time, I found for most fields a substantial stability Two phenomena seem to occur One is that a field develops and moves up to sort of a high point and then remains stable over a long period of time The other is that particular areas of interest develop for a short time, command the attention of substantial numbers of persons, and then drop out The field of "Child Psychology" is very stable, and over the 28 year period the proportion of articles devoted to this field has been very constant in relation to the total field The field of "Gerontology" was a very minor field, with almost no interest when the *Abstracts* were begun It has steadily increased with a slow and gradual growth, and that suggests permanence But I have no answer to the question as to whether 2, or 5, or 10 per cent of the articles should be devoted to gerontology

Another time comparison may be made The Shock bibliography which appeared in 1951 lists 18,036 abstracts in gerontology for the world between 1900 and 1948 while *Supplement One, 1949–1955* lists 15,983 The rate per year from 1900 to 1948 was 360, while the rate per year from 1949 to 1955 was 2283, or six times as great While these figures, which could be further broken down, are not, strictly speaking, comparable, they do show the great shift in scientific interest in all areas of gerontology In the Introduction to the *Supplement,* Shock (1957*a*) points out that in 1948 there were four journals in the world devoted to gerontology, whereas in 1957 there were seventeen

In the second edition of *Trends in Gerontology,* Shock (1957*b*) makes an analysis of progress in the whole field in various ways but does not, as would be desirable for our purposes, compare the psychological and social field with the biological and medical field It is clear, however, looking at his data, that scientific interest in gerontology is not confined to one nation, one world area or one discipline

Shock (1957*b*) also analyzes the changes in the goals and content of research in gerontology and finds a shift from descriptive studies of age changes to experimental and designed studies that seek to answer more fundamental questions He also finds a marked increase in the number of laboratories that are devoted to research on aging and an increase in the support of research on aging by grants and in the availability of experimental material in the form of animals maintained throughout the life span Although he is considering the entire field, he does point out that in the area of psychological and social studies proportionately more research is being done

on stratified samples of the population and on people living out in the community rather than people in institutions All this adds up to much greater sophistication in the scientific sense in stating problems in securing samples and in designing studies

SUMMARIES OF CURRENT RESEARCH

Recently several surveys of the psychological and social research on aging in Europe have appeared of which the most comprehensive is that of Welford (1958b) in the supplement to the April 1958 issue of the *Journal of Gerontology* In fact this entire supplement presents a series of papers given at a special symposium on A Survey of European Gerontology held at the Tenth Annual Meeting of the American Gerontological Society in Cleveland November 1957 Shock (1957b), in the second edition of *Trends in Gerontology* presents a brief description of various laboratories in Europe with emphasis however mainly on biological and medical research Heron (1957) has a brief discussion of the present status of research on psychological changes with age The most recent summary of gerontological research (mainly American) to appear in the *Annual Review of Psychology* is that by Birren (1960) The report of the Bethesda Conference on the *Psychological Aspects of Aging* (Anderson 1956b) also summarizes many research studies (mainly American) in the area of psychological and social behavior and suggests future problems

For a comprehensive survey of research and extensive bibliographies the reader may consult the other *Handbooks* in this series published by the University of Chicago Press under the auspices of the Inter University Council of Social Gerontology The first edited by James E Birren and entitled *Handbook of Aging and the Individual Psychological and Biological Aspects* presents a systematic and complete summary of the state of our present knowledge in the psychological area including personality and adjustment The second *Handbook*, edited by Clark Tibbitts and entitled *Handbook of Social Gerontology Societal Aspects of Aging*, covers the social and economic areas

For access to specific research studies either past present or future the reader should consult the various comprehensive bibliographies (Shock 1951, 1957a) the 'Index to Current Periodical Literature in the *Journal of Gerontology* and the indexes or abstracts within special fields such as those in the section on 'Maturity and Old Age in Psychological Abstracts A new abstract journal entitled *Gerontology and Geriatrics* appeared in 1958 under the auspices of the Excerpta Medica Foundation of Amsterdam which maintains an international medical abstracting service

II RESEARCH IN VARIOUS COUNTRIES

We may now turn to a brief description of research projects in various European countries

A United Kingdom

Any presentation of the work on aging in the United Kingdom within the limited space available in this chapter will of necessity be inadequate and will either omit some projects or barely mention others. At the Third International Congress as shown in Table 2 there were twenty six papers and at the Fourth International Congress there were twenty five in the psychological and social fields from Great Britain When compared with other countries the United Kingdom is then a large producer of papers on aging

For a decade or more there has been a constant flow of papers monographs and books dealing with all aspects of aging—medical biological psychological social and economic—largely because of the interest of the Nuffield Foundation which has served [illegible]
ar
ac
[illegible] foundation and parallel with it Lord Nuffield made other grants which reveal his

personal interest in the problems of older people The Andrews and Brunner book (1955) gives an account of Lord Nuffield's life and of his many benefactions

Briefly, the foundation was established in 1943 with £10,000,000 to further (1) the advancement of health and the prevention of sickness by medical research and teaching, (2) the advancement of social well being by scientific research and the improvement of education, (3) the care and comfort of the aged poor, (4) the advancement of education, and (5) such other charitable purposes as shall be declared by Lord Nuffield or the vote of the trustees Note the broad definitions of the tasks set for the foundation and the great flexibility of its conception

Over the years the foundation has devoted its largest sums to the "care of old people" It also set up the first general program for systematic investigation of the problems of aging It has, in addition, supported much research in other areas of medicine, biology, and the social sciences as well as research in the physical sciences and in agriculture Grants have been made throughout the United Kingdom Included in the grants for fundamental research in the biological, medical, and social sciences have been specific grants for research on aging, in addition to those for the care and comfort of the aged poor Also included in grants for medical research have been grants for studies of the diseases of old age The foundation also established Nuffield Gerontological Research Fellowships

In 1947, as a result of a report by the Rowntree Committee, the foundation established the National Corporation for the Care of Old People, which, in addition to funds from the foundation, secures contributions from other sources either for specific programs or for administering benefactions The corporation has worked closely with other bodies and has stimulated other societies and local authorities It not only has made grants to voluntary societies providing homes for old people but has built such homes itself More recently it has shifted much of its emphasis from building homes to non residential clubs and welfare activities Still more recently it has undertaken long term studies to assess the needs of old people within an area and to provide services in that area as a demonstration of what can be achieved Thus the studies of the corporation have a very practical slant when compared with those of the foundation

It should be noted, however, that the foundation's concern with older people though bulking large throughout its program,[2] does not constitute its entire program, which is broad enough in scope to include almost any research or practical field that looks toward human betterment Moreover, the foundation program has opened up areas of research and practice and then, as needs and scientific interests have changed, has shifted emphasis

Many of the studies of British origin briefly described or listed in the Welford (1958b) survey of psychological and social gerontology in Europe were financed by the Nuffield Foundation This report covers measures of human capacity, experimental studies of human performance, employment and retirement and social and economic problems and has a bibliography of citations to current work In the psychological area the studies on aging and skill (Welford, 1951, 1958a) are the outcome of the research of the Nuffield Research Unit into Problems of Aging at the Psychological Laboratory, Cambridge, which has recently closed its program At the present time a number of studies in the social field are under way through grants from the foundation, of which only a few may be mentioned as indicating trends

1 A study of the economic cushions which people carry forward with them into retirement has been started by Utting at Cambridge He is attempting to determine the amount of clothing, household equipment, property of all sorts, linens, silver,

[2] See Case Study No 13, pp 448-56 for a fuller account of the work of the foundation in the field of aging

etc., possessed by persons over 65 years, in order to determine the resources available to meet aging At present this study is in the pilot stage in order to formulate techniques If the techniques can be developed and the co-operation of older persons obtained it is expected that this study will be extended to other communities.

2 The studies of aging in various industries and of the opportunities for elderly workers some of which have been reported by Le Gros Clark are being continued This type of study is carried on in one industry after another and covers various factories business firms trading organizations, etc. Special studies are being made of women in industry and of retired women Studies are also being made of provisions for retirement and the manner in which retirement is being met by aging men and women This is a whole program of studies to illuminate the working conditions and the pre- and postretirement conditions of workers of all types It seeks to answer questions about elderly workers such as 'Who are you? 'What are your opportunities? What part time opportunities for employment are there?' Could more opportunities be developed? etc

3 At the University of Bristol there is a unit for research on the employment of older workers supported by a grant from the Nuffield Foundation A study of the age structure in the engineering industry has already been *published* The purpose of the project is to identify aging effects in industry and to find methods of minimizing them not so much to solve employment problems as to reduce wastage of workers when jobs become too demanding The technique is primarily that of the field study The theoretical problems raised by the field studies are then studied in the laboratory One experimental study using pursuit tracking behavior seeks to determine age changes in *performing* continuous tasks which involve 'short term storage' while another is concerned with the effect of age on the monitoring of movement In volved in these studies are Murrell and Griew

4 At the London School of Economics, Townsend, Titmuss, and Abel Smith are making an extensive study of the factors of all types which lead older persons to enter institutions and to live in them Some emphasis goes to the types of relations maintained with the person's family outside the institution Analysis is also being made of the institutional organization and pattern of functioning in homes for the aged, nursing homes, and other types of institutions The investigators are concerned with the problem of what leads to the decision to enter an institution and, after the person is in the institution, what the effect of institutionalization is Involved also is some study of the homes and environments from which institutionalized persons come.

5 The projects under the auspices of the National Corporation for the Care of Old People involve surveys by means of interviews, which are made by welfare workers These seek to determine the needs of older persons and the best ways of meeting them This corporation is asking questions as to the gaps in the present program of service and how the gaps are to be met. It studies the work of private as well as public agencies and the clientele reached by each At present one study had been completed in Andover, and projected studies are to be done on samples in Nottingham and Sussex.

In England some studies are going forward with government support within operating agencies Often these involve academic co-operation For instance, the National Assistance Board, which handles two-thirds of the aged in Britain, surveys the needs of older people The Ministry of Labour has set up an Advisory Council on the Employment of Men and Women and is concerned with the arbitrary age at which employment ceases

Specific governmental support for research on aging comes from the Medical Research Council, which usually supports units attached to university departments

or medical schools and sometimes supports individual workers by direct grant Recently, the Medical Research Council has formed a "Group for Research on the Occupational Aspects of Aging' which is attached to the University of Liverpool, with L S Hearnshaw, professor of psychology, as honorary director, and Alastair Heron as full time deputy director The objectives of the new group are as follows (a) experimental studies of the psychological concomitants of normal changes with age in the main perceptual modalities the present emphasis being on vision and hearing (b) studies of various aspects of psychological "rigidity' (these include examination of both intellectual and emotional aspects of this problem and of its relevance to industrial training and retraining procedures) and (c) investigation of attitudes toward aging and its consequences as held by those concerned and by others of various ages and occupational status

During 1958 this group in addition to laboratory studies carried out a survey of aging in over thirty manufacturing firms representing a wide variety of industrial activities One objective of this survey was to lay the foundations for intensive studies of particular occupational problems of aging wherever possible of a longitudinal as well as the familiar cross sectional kind Attention was also given to the development and study of 'education for retirement programs

In addition to the active research going forward in Britain on "normal old people, there is interest in elderly patients in the research departments of mental hospitals For example in the Department of Psychology of the Institute of Psychiatry in Maudsley Hospital a series of studies deal with psychological functions in elderly patients These started with attempts to study the relations between cognitive difficulties, memory impairment and brain damage in psychiatric patients over 60 years of age Studies of learning of memory functions, of the capacity to reproduce designs and of memory disorders have resulted or are in process These studies under Inglis not only are of interest in connection with psychiatric patients but also have significance in terms of methods and results for the study of normal aging

In concluding this all too brief summary may I express appreciation of the richness and variety of the approaches made in Britain to the study of older people

B France

In France a series of major research projects on the psychology of aging are being carried on by Suzanne Pacaud who reported at the Third International Congress on the age relations of a number of psychological variables on four thousand subjects between 12 and 55 years She was concerned first with age changes in memory and in intellectual and psychomotor functions and second with the effect of education upon the decline of these functions In process now is a study of the factorial structure of these psychological abilities as a function of age She is presently extending this series of researches upward in the age scale and in collaboration with Professors Laugier and Piéron and with Dr Coumétou is making psychological and sociological studies on persons between the ages of 55 and 75 years In addition she has completed integrating experimental results on the age relations of a number of physiological functions in co operation with Professors Laugier Piéron and Bourlière and with Dr Coumétou These interrelated studies represent an ambitious program

The Centre de Gérontologie was established in 1957 under the sponsorship of the Association Claude Bernard a non profit organization concerned with the development of biological and medical research in the Paris hospitals F Bourlière professor of gerontology at the Paris Medical School is the director of the Center which is organized under four sections biological physiological psychological and socioeconomic The main researches now

in progress are In *biology and physiology*, (1) a longitudinal research on two hundred subjects between 45 and 95 years of age to determine the influence of nutrition on the aging of some physiological functions, (2) a parallel study on the same subjects on the variation, with aging, of the thresh olds of gustative perception, (3) research on the aging of skin evolution and involu tion of metabolism, and the effects of ag ing on the liver regenerative function, and (4) other research on aging in the field of biochemistry and pharmacology In *psy chology*, (1) differential aging in a homogeneous population of teachers, (2) psy chomotor task measurement in a general population of aged people (3) interest inventories for the aged and (4) differ ential aging in a population of bicycle fans In *sociology*, (1) a study of attitudes before and after retirement in a sample of teachers in Paris and (2) a pilot study on the causes of the higher rate of masculine mortality in the population over 60

J R Tréanton of the Institut des Sci ences Sociales du Travail of the University of Paris is making a study of the adapta tion to retirement of 270 persons who have had their retirement pensions 1 year or more and who continue to live in Paris A preliminary report of this study was given at the Fourth Congress He obtained in formation on the level of economic life the adaption to urban living the kind and frequency of their social relations (includ ing those with the family) the expecta tions and aspirations for the future and the general attitudes toward retirement life social security, and their place in society

Tréanton is also studying the attitudes of managerial personnel over the age of 40 with special emphasis on the problems of aging and of social security The first part of this study is being made on seventy managers in the chemical industry to be followed by studies in other industries The attitudes he is concerned with are hopes for stability of employment, attitudes toward the organization of managers, attitudes and provisions for retirement, attitudes toward work, and productivity in retirement work

In the sociological field in France the study of aging suffered a great loss in the death of Jean Daric, who had made demographic studies of older people, more espe cially studies of age grading, and who had a number of projects under way He had wide interests in all the social aspects of aging

C West Germany

Under the direction of Klaus Riegel, a large research project on the relation between the mental abilities and thinking processes of older persons and their in terests, activities, attitudes, and adjust ment was carried on at the University of Hamburg For comparative purposes a control group of younger persons was used In the pilot study in which the procedures were developed, 74 persons above 65 from old age homes were compared with 56 persons who had an average age 17 years In the major study 450 persons above the age of 55 years from Middle and North Ger many, stratified within groups of 150 cases from 55 to 64, 65 to 74, and 75 to 84 years, respectively, by sex, vocation, source of income and residence were compared with 160 17 year-olds matched by sex educa tion, and vocation The older subjects were secured in factories and clubs and by door-to-door contacts, the younger subjects, from various technical schools and high schools

The Hamburg Wechsler Intelligence Scale was given to all subjects in order to study the effects of intelligence as well as to control it and to extend the norms of the test to age groups above 60 An item by item comparison between the younger and older subjects is being made Six new verbal tests (synonym, antonym, selection, classification analogy, and ordering) were also developed and applied in the pilot study, which showed no difference between the older and younger groups for the synonym test and increasing differences in

the other tests in the order listed The results of the tests have also been factor-analyzed It is hoped that these new tests will give insight into intellectual changes in old age and yield an index of intellectual deterioration A word association test is also being used (made up of the same stimulus words of which the tests of verbal functioning are composed) in order to isolate changes in associative verbal behavior

Attitude inventories of the Likert type are used to measure rigidity, dogmatism, and the attitude toward life In the pilot study other measures of rigidity were tried out A measure covering the intensity and span of interests is also being used A general questionnaire covering personal data life history, social interactions, and social relations consisting of 125 questions, broken down into ten different subscales covering adjustment and activity within the family, social life, leisure, work, and other areas was developed and is in use

A very extensive statistical analysis of the data is now under way This involves developmental and age comparisons as well as the interrelations between the variables In addition, small samples are to be drawn out of the main sample for future studies of the verbal behavior and perceptual abilities of older persons In drawing such samples, various controls can be exercised in terms of the data available on the subjects This is a special advantage of the design

While the present study represents a cross sectional design, the records will be kept in the hope that some 5 or 10 years hence the study may be repeated on the same subjects This investigation is aided by a grant from the foundation s Fund for Research in Psychiatry

Another study is going forward under Hans Thomae at Erlangen This is concerned primarily with personality changes in men between 30 and 50 years Although it is a longitudinal study in which the men are interviewed every half year, it also yields cross sectional age comparisons Questionnaires and semistructured interviews are used which were developed on the basis of a preliminary pilot study The final group to be followed consists of one hundred men At present the project is financed for 3 years, with some hope that it will be continued longer A preliminary report is in process of publication

Although both the Riegel and the Thomae studies have implications for social behavior, there seems, in general to be a lack of designed sociological studies Nevertheless, at the international congress at Merano several theoretical and philosophical papers on aging were presented by professors from West Germany, who thus evinced interest in the implications of aging

A major study of the characteristics of social security recipients is going forward under the Co ordinating Committee of the Social Sciences Institutes, on which information can be obtained from the executive secretary, Professor Specht at Cologne-Lindenthal [3] Within the framework of this larger project the Social Science Institute at the University of Frankfurt, under the direction of Professor Th W Adorno, is making a study of the old age expectations of workers and white-collar employees while they are still productively employed

D Scandinavian Countries

In the Scandinavian countries the care of older persons is generally at a very high level One cannot but be impressed with the housing, the institutions, the philosophy, and the general organization of the programs But a person who has grown up in scientific research wonders how this has all come about without an extensive series of studies, each rather specifically designed which have been integrated into a sound body of practice But the care of the old in society cannot wait for the results of the most recent investigations, it is with society as a practical problem always Hence societies meet their problems as best they can in the light of their own present knowl

[3] See Case Study No 14 pp 457-59

edge and their own level of development. Involved also is a kind of social trial and error, like the trial and error in the learning of the individual, except that it may be much extended in time and involve many individuals and organizations Some practices are eliminated in time, and some are retained and developed But sometimes wrong directions are taken and rigidities develop Because these may actually encumber the society and adversely affect many people, they need re-examination with modern techniques of research

Since the advent of modern science, society increasingly substitutes a systematic and orderly method of solving its problems. At first it uses research techniques haltingly and with suspicion, later it uses them freely and with almost too ready acceptance In the more advanced stages of its use of research techniques society subjects many of its current practices to critical examination, seeks to understand why one procedure rather than another is used compares methods under controlled conditions and refines and elaborates a process which already has been going on slowly and unsystematically within the social structure Hence practice is in some respects and in some places ahead of science, in other respects and in other places behind it. Sometimes the scientist conceptualizes and rationalizes what is already known sometimes he moves out boldly from the present and changes wide ranges of practice

Sweden—In Sweden despite the very high level of care and the interest in older people pointed out by Havighurst in his chapter, there seem to be very few research projects Nor does there seem to be much interest on the part of psychologists However, sociologists, through the Swedish Institute for Public Opinion Research, made an interview study or poll in June, 1956 of a national sample of people over 56 The questions covered a wide range of interest activities and attitudes (For some of the material from this poll consult chapters viii and ix.)

One interesting project is under way Gunnar Boalt, at the Social Institute of Stockholm, is carrying forward a project in which he is studying a sample of people 60 years old who are leaving their jobs for pensions They are first tested with a mental test designed by Carl Ramfalk and by simple physical fitness tests and then matched in pairs One in each pair goes on pension, and the other is retained on his job Both are tested each year for 3 years in order to determine whether the pension lowers their physical or mental fitness The city of Stockholm is co-operating by letting a sample of pensioners remain at work while their paired mates go on pension But Boalt has found difficulty in maintaining the non working pension group because its members leave and then take other jobs with private employers An attempt is being made to interest private companies in a project of this sort

Denmark—In Denmark, under the Ministry of Labor and Social Affairs, a health study of older persons is now being carried on in which a stratified sample of persons is being interviewed While the questions center about health and its immediate problems, some have reference to adjustment In the immediate future a study of the effects of isolation upon the adjustment and health of aged persons is contemplated

The Danish Statistical Department is making a study on the living conditions of old age pensioners in different parts of the country, with particular reference to income and expenditures, the consumption of goods and housing

Another project contemplated by the Ministry of Social Affairs seeks to answer questions about the effects of the National Pensions Act of 1956 and will compare old age pensioners from the period before the new legislation with the pensioners after the new legislation and seek to find out why some apply and some do not apply for pensions The study will also include a study of the attitudes of old people toward the pension scheme

But the most significant feature on the

Danish scene is the Danish National Institute of Social Research, established by Parliament in 1958, which integrates work in the social sciences in government departments and universities In the past the conduct of research projects by separate governmental departments has proved cumbersome, particularly in recruiting staffs that changed from study to study This independent institute is financed by an annual grant from the government and is directed by a board composed of university professors in related fields and of representatives of government departments The director of the Institute (who is Henning Friis) is appointed by the Minister of Social Affairs at the recommendation of the board There is an Advisory Council composed of representatives of muncipalities, employers labor, social welfare institutes, and individual experts, which may make suggestions for research The Institute may receive grants from sources other than the government for special projects The Institute is conducting substantial projects in collaboration with various governmental agencies and university departments and gives grants to scientists working on special projects

The field of social gerontology has a high priority in the research program of the Institute It is planned to make a sample survey of the elderly, with particular attention to the problems of retirement work and the need for social service

Norway—In Norway, so far as I could determine, there is at present little or no research on the psychological and social aspects of aging There has been some discussion of a possible program in this area under the auspices of the National Association for General Health which has requested Mrs Eva Beverfelt to report on the possibilities

Finland—In Finland there is an active gerontological society which publishes a yearbook, *Geron*, that contains a variety of articles on older persons While these are in the main of the statistical and survey type or are reports of agencies, there is an occasional research study The journal reveals a broader interest in psychological and social problems than is true of many other European gerontological societies Anitra L C Karsten in particular, has been interested in the personality characteristics of older people and has recently concerned herself with the adjustment of older people in industry

E The Netherlands

In the Netherlands research on aging has been actively undertaken under the auspices of the National Health Research Council T N O of the Netherlands Foundation of Applied Scientific Research The latter organization covers industry, warfare, nutrition, agriculture, and health and promotes research in areas related to governmental activities The term "health" is very broadly interpreted and includes the psychological and social aspects of welfare and of mental health This organization sets up its own intramural projects and also gives extramural grants to scientists who apply The Netherlands Foundation secures the co-operation of public officials of universities and their staffs and of interested community officials and agencies in co-ordinated efforts toward the solution of problems

A particular area of concern to the National Health Research Council is aging In approaching the problem of the aged person it was felt that it was important to establish priorities by locating the central problems of aged persons Later specific projects could be developed The first step was to work out a questionnaire which covered the physical health and the psychological and social aspects of adjustment Special attention was to be paid to the need for assistance and dependency or, conversely, to independence and self help In an early pilot study this questionnaire for an interview was distributed to some twenty physicians who interviewed patients above the age of 65 After criticizing results and analyzing the questions in terms

of practicability, a new form of the interview is in use with the co-operation of general practitioners all over the Netherlands. Included is a section on psychological and social adjustment and a memory test similar to that in the Groningen survey mentioned later. The interview takes 3 hours per person.

In order to secure adequate sampling of the population, the lists of patients in the smaller towns are checked against the registrar's list and in the large cities against lists of sick fund registrants and then plotted on a map for location, and a letter is written back to the doctor to get whatever number of persons of such and such qualifications as are needed to make up an appropriate sample. If there is no return from a particular area, a special attempt is made to secure data from that area. Lists are made up from the various sources and if a patient or person refuses, the next number is taken. Appropriate proportions of senile, deaf and institutional cases are included. These questionnaires are returned to the central office and are checked. If part of the examination is incomplete or inadequate, the blank is returned to the doctor with a letter of explanation or request to supply the missing data.

The final sample is then a stratified sample of the whole population of Holland over the age of 65. The data are being machine processed. From the data it is hoped to get a comprehensive picture of the situation of aged persons from the standpoint of their physical and psychological characteristics, together with their needs, their amount of dependency and/or invalidism, and their capacity for self help. In addition to this large survey now being analyzed more intensive surveys have been made in particular communities, of which the best known is the Groningen survey in which three thousand persons over 65, randomly selected from four times that number, or all the aged persons in the city, were interviewed in their homes. This sample was divided into four age groups, 56–70, 70–75, 75–80, and 80 and over, and into two sex groups. The analysis of this data is now virtually completed and was of value in the development of the interviews being given over the whole of the Netherlands.

I have gone into some detail with respect to these surveys because I was impressed with the care taken in sampling as well as with the pilot studies and methods of checking the interviews. For more details the paper presented by van Zonneveld (1958) in the "Symposium on European Gerontology" at the Cleveland meeting of the Gerontological Society should be consulted. This presents the results and gives references to a number of health and medical surveys concerned with the aged which have been made in various countries in Europe. Often these surveys contain questions which are of much interest to the social scientist.

In addition to the surveys, there are other studies going forward under the auspices of the National Health Research Council. It has, for instance, subsidized research on aging in rats and mice, is making some studies of the housing of aged persons, and, in co-operation with various agencies, is studying social care. Still large in the planning stage is a project on how to develop and encourage independence and self help in older persons. This particular study involves the co-operation of the Ministry of Social Welfare and will use five or six regions selected at random.

Other projects of special interest are now supported. One is a project in the Rotterdam Municipal Home for the Aged which consists of a longitudinal study of the four hundred persons who are in that home from the present time until their death. The study involves periodic physical examinations, many types of laboratory tests, tests of sensory acuity, portraits at various ages, studies of psychological and social adjustment, and a final autopsy at death against which the cumulative records can be checked. It is hoped to view the subjects from every angle and to secure data which can be generalized to simi

lar institutions in other parts of the country

A second special project of general interest is being carried on at the Psychological Institute at the University of Groningen by F Verhage who is working in cooperation with a team composed of a *psychologist* a *statistician* and a clinical psychologist They are developing an intelligence test or *tests* at the *adult level* that can be applied to older and younger people At Groningen the Wechsler Intelligence Scale for Children has already been revised for use with Dutch children The new project seeks to develop a test comparable to the Wechsler Bellevue at the *adult level It is to be an individual rather* than a group test with scoring adapted to various kinds of persons and with a substantial number of subtests so that the tests which are not applicable may be left out in any individual case Material must be adapted to Dutch standards and culture Criteria relating to the level of difficulty as well as to the range and nature of the problems are to be used While this test will be useful for all types of adults a particular phase of the project involves a study of the applicability of tests to older people including a search for items or subtests that will be interesting to older people and adapted to their background At present pilot studies are under way with adults of various ages in order to make some preliminary selection of the test content *Later more intensive analysis will be* made for the final selection and standardization It is anticipated that 5 years is necessary to develop an adequate instrument

There are some other special projects in the Netherlands under independent auspices A study in Sittard in the south of *Holland under the auspices of J M A* Munnichs of the Psychological Institute at Nijmegen uses questionnaires and interviews in order to get together material that will reveal the thinking and needs of older people *and the relations within the* family of the older person with the members of the family Frequency of visits between family members where and how the older persons live who their friends are and *how often they are seen the time* schedule of their daily activities their hobbies and particularly their needs in terms of loneliness and social relations are being studied Plans are being made for a similar study in rural areas

F Switzerland

In Switzerland there has always been much interest in the biological and medical aspects of aging and some emphasis upon *methods of social care* but there has been little emphasis upon the psychological and *sociological aspects of aging and not much* interest on the part of university men in the behavioral and social sciences—all this in spite of the fact that good social statistics are available A current project that *may have implications for the future is* the study by F Verzar at the University of Basel which involves a longitudinal study of two hundred young employees of the Ciba Company by means of biannual physical and medical examinations *There* is some discussion of the possibility of *including psychological* measures At Basel there is also a rat colony of aging animals on which Jean Verzar McDougall has carried on an interesting study on the relation of old age in white rats to learning and relearning

G Italy

In Italy there is very high interest in the medical and biological problems of aging and much less work on the psychological and social side To a large degree the studies developed depend upon individual investigators and the resources available in the particular hospital or agency in which he is located Most studies seem to be largely clinical in nature and to represent an accumulation of cases rather than a specific design attacking a research problem in *terms of a particular hypothesis* Discussions with university men in psychology and sociology revealed only a mild interest

in the problems of aging persons Many of the generalizations with reference to psychological and social problems are left to medical men and social workers There are a number of active journals in the field of geriatrics

Some significant work has been done by individual investigators such as the recent study by Gemelli and Cesa Bianchi of motor tests on persons from 20 to 80 years of age and the Cesa Bianchi study of an Italian version of the Wechsler Bellevue Intelligence Scale and of the Rorschach on persons from 70 to 88 years There also seems to be considerable interest in the use of psychometric and projective tests as diagnostic devices with older persons who become patients in clinics or residents of institutions

H Russia

While no visit was made to Russia, I did have an opportunity to talk with several Russian psychologists at the International Congress of Psychology at Brussels They reported that there was virtually no interest in the problems of aging among Russian psychologists of their acquaintance They said that Russia was a young country with much scientific concern with the psychological and social problems of children adolescents, and young adults There was some interest among physicians in the problems of the medical care of older people and some programs of social care It was my distinct impression that there was no opposition to work on aging persons but rather that because aging had not yet become a significant social problem, scientists had not yet been stimulated to work on it Interviews with several psychologists from the satellite countries mirrored this impression

III Areas of Interest in Gerontology

Following are my impressions of the status of various areas of interest within psychological and social gerontology While my activities were directed toward designed projects, I have occasionally included other types of studies Even though one might expect interests within gerontology to reflect the dominating interests within the major scientific fields of a country at a particular time, this does not seem to be the case Interest in aging is specialized and cuts across disciplines Moreover, as one reads the scientific literature, there are many instances of investigators who work on a particular scientific problem and come up with data on older people, not so much because of interest in aging, but because older subjects were available or data were automatically collected on a large population which then was analyzed for age relations Much of our earlier knowledge about aging came about as a by product rather than a planned outcome

1 *Polling and interview techniques* — There is almost universal use of polling and interview techniques with various methods of sampling the general population Public opinion polls with a limited number of questions are made across populations Good examples are found in Sweden A more restricted type of polling is that in which a community or region is polled—sometimes because it can be shown to be typical of the entire population Another type of poll is a more detailed interview of persons, either taken at random or selected on some scheme of stratification, of which a good example is found in the Netherlands Such polls, which contain a variety of questions concerning the life of older people and their attitudes toward their treatment and experiences, have both psychological and social significance Van Zonneveld (1958) describes many types of surveys, chiefly of the interview type, that have been made in the various countries of Europe and comments on some of the problems involved

2 *Age changes in perceptual, motor, and other psychological processes.*—In many countries studies of age changes in psychological processes are under way In vision and audition these are often made

by persons interested in those areas rather than by persons concerned with aging The most comprehensive studies of a series of psychological processes on the same individuals are those by Pacaud in France

3 *Intelligence*—An interest that runs across the cultural pattern concerns tests of intelligence Intelligence tests for children have been either translated, adapted, or restandardized for use in almost every country, although interest in adult tests has lagged Now, for a variety of reasons, such as clinical, industrial, and military use, work goes forward in many countries Obviously, such measures, developed within the framework of a particular country and language, have many scientific and practical uses For many years England has been advanced in this area Recently tests have been developed in Italy and applied to older people Holland and West Germany have major projects going

4 *Personality tests*—A somewhat similar statement could be made about the Rorschach Personality Test, in which there is wide interest because of its use for assessment and diagnosis in clinics Studies made on persons of all age levels in various countries are scattered through the psychological literature But other personality tests are in clinical use and are under study in various countries Unfortunately, analyses of such results in relation to age are not always made

5 *Learning and education*—Except for the research done at Cambridge University, little work seems to be in progress on the acquisition of skills and the learning of simple and complex patterns despite the obvious need of such information in working out educational programs for older people When we turn to direct studies on educational methods for use with older people, the situation is even more striking The analysis of the bibliographies and of the programs of international congresses revealed surprisingly little concern with this area, as did the conversations with psychologists and sociologists in various countries While some data are available from the polls on the participation of older people in various activities, there is little concern with developing new activities or with exploring ways in which participation may be broadened by various kinds of educational programs geared to the older person

6 *Retirement*—In almost every country studies are concerned with the effects of retirement upon the health, behavior, interests, attitudes, and adjustment of older people Since the number and the proportion of retired persons are increasing everywhere, problems arise One would wish for more designed studies that are concerned not so much with a descriptive analysis of the characteristics of retired persons as with the exploration of methods that might be used to increase the participation of retired persons in community activities to utilize their skills and knowledge, and to discover how to develop the feeling of being worthwhile that comes with participation

7 *Self help*—Closely related to the problem of retirement as well as to the problem of care is that of building more autonomy in older persons with respect to their own care, that is, the problem of self help This is also related to the problem of rehabilitation While workers in many countries are aware of the problem and in fact see it as of great importance because of the increasing burden placed upon the state by the care of the old the amount of research designed to explore the underlying principles and give us the basis for a practical program is negligible

8 *Social behavior*—In the various polls and surveys some data on the extent and types of social participation of older persons and on their attitudes toward such activities are available But there is little or no designed research on the organization of social groups on how most effectively to secure participation on the ways of reaching ' lonely old people and enriching their lives etc Nor are there experiments in which the group atmosphere the

group size and the group activities are varied systematically in order to compare different techniques and procedures

9 *Housing*—In many European countries there are fine housing developments for older people yet their practice seems to grow out of practical experience rather than systematic experiment Much of the material seems to be on an ideological rather than an empirical level Observations could well be made on the effects of various types of housing and equipment on the adjustment and attitudes of older people

10 *Institutional organization and management*—In all countries there are institutions of various sizes and types for older people operated under a variety of aus p ces with various patterns of organization *and staff arrangements* It occurred to me as I visited some of them that there was an opportunity for ecological and observational studies that would give us understanding of the various principles that underlie good *institution* organization and management in terms of the effects produced in the behavior and attitudes of older people

11 *Working studies within departments and agencies*—In all countries studies are made fo d—

these studies concern needs employment housing medical care social services income retirement—almost any practical problem about which decisions have to be made Much of this research is not conceived

nor is

Usual

graph uupl cated and given limited circulation But among them are some using good techniques that seem to be of more general value and that could well be made more widely available

12 *National and cross-cultural surveys*—As one observes the work under way in various countries he cannot help but be impressed with the desirability of making studies within them with similar techniques of sampling and similar methods in order to secure data that will permit cross comparison That there is interest in such a survey is indicated by a conference organized by the European Section of the Social Science Research Committee of the International Association of Gerontology and held at Copenhagen, October 19–23 1956 and which has recently published a report entitled *The Need for Cross National Surveys of Old Age*

An introduction by Professor Titmuss of the London School of Economics which

formulated suggestions for cross national research in three areas (*a*) pensions assistance and levels of living (*b*) work and retirement and (*c*) family and institutional care These reports are followed by papers prepared by research workers from various countries giving examples of surveys undertaken or needed

While this report is limited largely to surveys and collections of data which are related to the practical problems of the community and the state there is no necessity to limit co-operation across national and cultural lines to the survey type of research The techniques could be ex tended

social significance In any event it is likely in this field as in other scientific fields looking to the future that there will be an increase in the co-operation of scholars and scientists across national and cultural lines along with increased facilities for the interchange of information

IV FINANCE AND THE ORGANIZATION OF RESEARCH

That the conduct of research is affected by the financial aid made available from

governmental and private sources and by the interrelations between governmental agencies and universities is clear from my impressions of the European scene In some countries research is largely a matter of interest on the part of a particular investigator who uses whatever facilities he has himself or are available within his university without outside financial aid In Great Britain there is a large foundation which promotes research by direct grants to investigators and to centers both within and outside universities that are interested in aging research In the Netherlands there is a comprehensive governmental plan which brings governmental agencies and university investigators together This agency also carries forward its own projects In other countries there is some direct financing of research by particular government departments, but, even where foundation or governmental aid is available, some research is still carried on by individual investigators

What seems to be clear is that the field of aging presents particular difficulties which operate to increase the cost of research At younger ages when children and youth are in school or university, numbers of persons are readily available But the student of aging has to go out and secure his subjects either through the co operation of industries and social agencies or by house-to-house canvass Perhaps this also explains why university social scientists are not quite so interested in the problems of aging as some feel they might well be Generally speaking the projects now going on involve extensive co-operation over a period of time with many people Usually there are several investigators or an investigator who has the assistance of a staff or students If research is to be developed on a substantial scale, financial support seems to be necessary

Next, it is evident that, in spite of the fact that many European universities are financed by the state, just as are the departments of government, the strong tradition of intellectual independence which operates within universities even though there are individual exceptions creates difficulties for research projects which involve the co-operation of university departments and departments of government Within universities, too, this strong tradition of independence limits the collaboration of departments on research projects Although American universities and governmental divisions also vary greatly in this respect nevertheless the rigorous separations of our earlier history seem to be breaking down in the face of the complex problems that are presented to the scientists of today In many instances and in various sciences this leads to scientific teams rather than single individuals Teams may be within a discipline or across disciplinary lines

There is evidence in the formation of such bodies as the Netherlands Foundation for Applied Scientific Research and the Danish National Institute of Social Research that European countries are moving in the same direction as has the United States with its National Science Foundation and its National Institutes of Health Since the National Institutes of Health carry on both an intramural program of research as a division of the Public Health Service and an extramural program by making grants to universities and research organizations the Institutes probably afford the better model of what is likely to come In any event it is clear that a type of organization can be developed with the modern state that will facilitate research both by groups and by individuals both across and within disciplines In talking about research organization with various people in different countries there appears much similarity in the actual problems of conducting research As far as the facilitation of research either by financial support or by a form of organization that will free scientists within governments and within universities to work together, we are still in a process of social experimentation

V CONCLUSION

As we move across the various countries in Europe we see, first that scientists are much more concerned with the medical and biological aspects of the aging problem than with the psychological and social aspects The problems of the chronically ill as well as the problems of preserving life have been more pressing than the problems of psychological and social adjustment Moreover, biologists who see the life cycle in its completeness in lower organisms become interested in the process of aging as a significant area for research

Second it is clear that the problems of the practical care of aging persons and of economic assistance and government support arise in every country and that with industrialization problems of retirement arise No one who has visited the various countries can fail to note the cumulation of much practical knowledge through social experience with reference to the care and handling of older people With the development of social security and of pension plans and the increasing longevity that results from modern medicine the financial burden of caring for older people is increasing As a result there is more awareness of the necessity of increasing the possibilities of self help and of self care through the design of living arrangements household equipment the provision of occasional nursing and domestic care at moments of great need etc in order that the person may care for himself the remainder of the time What is sought from research workers is more accurate knowledge of means of assessing older persons of their status in the community of their resources and potentialities and in particular, some knowledge of the techniques by means of which they can become more effective during a longer portion of their life span This involves a study not only of age changes but of the factors th[illegible]

chological and social aspects of aging is in most countries, as in the United States, in its infancy Not many psychologists or sociologists, either in government or in universities, are directly concerned with the problem of aging There is, of course, definite interest on the part of some, and as has been shown, an appreciable amount of research is going forward But it is quite evident that substantial research is necessary in order to build the basic methodology upon which practical applications can be made We are concerned with substitution of valid or empirically supported generalizations for the half formulated practical principles followed in the present development of programs We are also concerned with understanding the basic processes of aging and the environment which facilitates or retards the process

Fourth each country attacks its problems in its own characteristic fashion in terms of its own traditions of scientific work There are however, common approaches and a substantial amount of interchange of scientific information

Fifth a beginning has been made in an attempt to secure comparable statistical and scientific information across national and cultural lines by means of standardized survey techniques A similar cross national or cross cultural approach could well be extended to experimental and ecological studies of age changes and other psychological and social problems

Sixth there is great need of more financial support for research in the psychological and social aspects of aging Support is now provided in a variety of ways with substantial government support emerging as a typical pattern

Seventh almost everywhere it seems to be difficult to secure the interest of university social scientists in the practical problems presented to society by aging and aged persons and in the theoretical problems of aging This problem is not unknown in the United States It is being met both in the United States and in Europe

by establishing institutes and making funds available for co ordinating research efforts

Eighth, there is also concern about the recruitment of advanced students and younger scientists for the field Adequate financial support of research, the develop ment of research teams, and the organiza tion of institutes afford a partial answer to this problem As the scientific literature in gerontology increases and more problems emerge, younger scientists in their forma tive years are more likely to be recruited

REFERENCES

AMERICAN PSYCHOLOGICAL ASSOCIATION 1927–54 Psychological abstracts, Vols 1–28 Washington, D C

ANDERSON, J E 1956*a* Child development an historical perspective Child Development, 27, 181–96

——— (ed) 1956*b* Psychological aspects of aging Washington, D C American Psycho logical Association

ANDREWS, P W S, and BRUNNER, E 1955 The life of Lord Nuffield a study in enter prise and benevolence Oxford Basil Black well

BIRREN, J E (ed) 1959 Handbook of aging and the individual psychological and bio logical aspects Chicago University of Chicago Press

——— 1960 Psychological aspects of aging Ann Rev of Psychol, 11, 161–98

HAVIGHURST, R J 1958 A world view of geron tology J Gerontol, 13 (Suppl No 1), 2–5

HERON, A 1957 Psychological changes with age, the present status of research *In* W B YAPP and G H BOURNE (eds), The biology of ageing, pp 91–100 New York Hafner Publishing Co

INTERNATIONAL ASSOCIATION OF GERONTOLO GY 1955 Old age in the modern world Re port of the Third Congress held at London 1954 London E & S Livingstone

——— 1957 Programme Fourth Congress held at Merano, Italy, July, 1957

——— 1958 The need for cross national sur veys of old age report of a conference at Copenhagen, October 19–23, 1956 Ann Arbor Division of Gerontology, University of Michigan

SHOCK, N W 1951 *A classified bibliography of* gerontology and geriatrics 1900–1948 Stan ford, Calif Stanford University Press

——— 1957*a* A classified bibliography of gerontology and geriatrics, Supplement One 1949–1955 Stanford, Calif Stanford Uni versity Press

——— 1957*b* Trends in gerontology 2d ed *Stanford Calif Stanford University Press*

TIBBITTS, C (ed) 1960 Handbook of social gerontology societal aspects of aging Chi cago University of Chicago Press

VAN ZONNEVELD, R J 1958 Public health and [illegible] rch and programs

[illegible]

W[illegible]

[illegible] ty Press

——— 1958*a* Ageing and human skill Lon don Oxford University Press

——— 1958*b* Psychological and social geron tology in Europe J Gerontol, 13 (Suppl No 1) 51–67

XI

Résumé and Implications

ERNEST W BURGESS

Five main questions challenge our attention in concluding our survey of aging in European countries of Western culture

1 What general conclusions can be drawn from European experience in dealing with older persons and their problems?

2 What issues emerge in the comparison of developments from country to country in social action to cope with the problems of aging?

3 What values and meaning have the implications of the survey of European experience for our thinking and action in the United States?

4 What are the contributions from cross national comparisons at present and to be expected in the future to the science of social gerontology?

5 What is the relation of social action in behalf of the aging upon their independence initiative and autonomy?

I General Conclusions

The first conclusion from the survey of six European countries selected to be representative of Western culture is that the conditions which produced personal societal and governmental concern for the aging were similar in all these countries

A Similarities

The basic social change in each of these countries was the transition from agriculture to industry Industrialization brought with it a series of consequences which impinge upon older persons the growth of cities and urbanization the shift of employment from the home to the factory, the accelerated breakdown of the extended family, and the emergence of the small unit of husband wife and children

1 *Change in the economic structure*—The basic change in the economic structure common to all six countries was the result of the industrial revolution The old economic system of the family as the unit of production on the farm and in the shop was increasingly supplanted by the factory Women as well as men gave up home production to work as employees in ever larger industrial organizations The proportion of self-employed and entrepreneurs steadily declined

Retirement of older workers at a fixed age at the initiative of the employer replaced the custom of gradual reduction of working time by the self-employed.

Even in farming beginning before the industrial revolution the nuclear family was replacing the three generation family as the economic unit. The reason was that the iron plow which needed only one man with two horses was supplanting the old plowing system which required two or three pairs of oxen operated by four or five men

2 *Change in the social structure*—The change in the social structure lagged behind that of the economic structure The extended family dominated by the aging parents deprived of its economic role was

gradually reduced to a network of changing social relations A transition stage of extended family relationship has been observed by Peter Townsend and others in certain working class industrial urban districts in London Here, after marriage, grown up children tend to live near, but not often with, their aging parents This type might be called the "maternal extended family" revolving around the grandmother and largely sustained by her daughters City life in general, with its increasing residential and social mobility, still further disrupts the extended family and favors the emancipation of the conjugal or companionship unit of the husband, wife, and children from the control of the extended family A decrease in the necessity and obligation of children to support needy parents has followed the general enactment of laws for old age insurance or pensions

3 *The trend to the dependence of the aging upon organization* —In the six countries of Western culture the tendency is for older persons to depend for the satisfaction of their needs less upon their children and other relatives and more upon organizations The main reliance of the aging for economic support is now upon programs of old age and survivors' insurance, pensions, and old age assistance administered by the government For meeting other needs, older people turn to an increasing variety of large organizations Outstanding among these organizations are (*a*) the government, (*b*) business and industry, (*c*) labor unions, (*d*) the educational system (*e*) the church, (*f*) welfare agencies, and (*g*) other voluntary associations Fewer older people are now living with their children and more of them in dwellings specially designed for them and often subsidized by the government In the field of health there is a network of clinics, hospitals, convalescent centers, visiting nurses, etc

4 *Social action for the aging* —All six European countries have shown concern for the problems of older persons They all have taken much the same action for the welfare of the aging The priority of measures has been similar in all these countries (Havighurst, 1958)

Legislation to insure a minimum of income for older persons tended to come first Programs of old age and survivors' insurance were first introduced in Germany in 1889, in France in 1910, in Sweden and the Netherlands in 1913, in Italy in 1919, and in Great Britain in 1925

Second, public concern and action were next in the area of housing and physical and mental health In large measure this was a part of the larger interest in public health In all Western countries concern and organization first were focused on child and maternal health, then upon the communicable diseases of middle age, and, finally, upon the health of older persons

More recently interest has developed in the personal problems of aging people, such as those of family relations, loss of occupational role by retirement, lowered status, isolation, and loneliness

B Differences

The similarities among countries appear to be much more striking than the differences Yet differences exist and deserve recognition

1 *Industrialization* —The degree of industrialization is greater in certain countries than in others The United Kingdom and West Germany are the most highly industrialized Sweden and the Netherlands are less industrialized France and Italy are semiagricultural The relative numbers of self employed in the labor force vary in much the same way The United Kingdom, being highly industrialized, has the smallest proportion, France and Italy, being semiagricultural, the highest percentage, and Sweden and West Germany are intermediate The differences in urban and rural population show much the same distribution The percentage of urban population is highest in the United Kingdom and West Germany, lowest in Italy, and intermediate in the other countries

Differences in the stage of industrial growth appear to be more important for

the status of the aging than variations of these countries in cultural heritage or historical background At any rate, other differences significant for the welfare of older people among the countries seem to be largely the result of the degree of industrialization

2 *Changes in economic structure*—The degree of industrialization brings with it shifts of the aging in the economic structure Consequently, in less industrialized countries a greater proportion of older as well as younger workers are self-employed, are engaged in work at home rather than in the factory and thus determine the time and character of their retirement.

3 *Changes in social structure*—The family structure has changed at a greater rate in the highly industrialized countries than in those which are still largely agricultural such as Italy and France The extended family as a social network survives with diminished functions in certain situations even in industrial districts, as in Great Britain It flourishes with much of its earlier vitality and significance in certain rural districts in every country where farming is still largely a family operation

4 *Differences in organizational structure*—The movement in the development of large organizations has proceeded more rapidly in countries like the United Kingdom and West Germany than in less industrialized nations such as France and Italy But in all countries there has been a tremendous growth in governmental and other organizations No attempt has been made in this survey to compare the development of the organizational structure country by country Our assumption however is that it would correspond closely with the degree of industrialization

5 *Differences in social action on behalf of the aging*—While the general pattern for meeting the needs of the aging has much in common in European countries there are considerable and often important differences in details. This is to be clearly seen in the legislation for social security

All six European countries have laws for old age and survivors' insurance, yet the minimum age of eligibility in these six countries varies quite widely For men it ranges from 60 to 67 and for women from 55 to 67

Marked differences are observable in the sources of funds for insurance or pensions In the Netherlands the cost of the system is borne entirely by the insured persons, except that the government contributes on behalf of low income persons and bears any eventual deficit In France and Italy the insured person and employer are the sources of insurance funds In Sweden the contributions come from insured persons and the government In Great Britain and in West Germany the cost of insurance is shared by the insured person, the employer, and the government.

The Netherlands is the only country that has an *automatic adjustment of the benefit*, calculated at 6 month intervals, and related to a 3 per cent increase in wages West Germany has adopted the principle of adjusting outstanding pensions by special legislation to future changes in average taxable earnings on the basis of the status of pension finances and of the national economy In Sweden old age benefits include, besides the basic amounts, a fixed supplement, a cost-of living supplement, and a housing supplement

The coverage by old age and survivors' insurance varies The Netherlands includes all permanent residents aged 15–64 Sweden takes in all citizens 18–66 In Italy the program covers all employed persons, males from 14 to 59 and females from 14 to 54 In Great Britain the program embraces residents (men 15–65 and women 15–60) but is not compulsory for self employed or persons with the lowest income or married women West Germany has one system for wage-earners, another for salaried employees earning not more than DM 15 000 annually, and special systems for miners, self-employed craftsmen, and civil servants France has separate systems for non agricultural employees, agricultural

employees, miners, railroad employees, seamen, public employees, and self-employed persons.

Retirement from employment does not appear to be a requirement for receiving benefits except in Great Britain for 5 years beyond pensionable age and in West Germany if pensions are paid before reaching the normal eligibility age of 65.

Great Britain has flat rates of contributions and of benefits. In other countries contributions and benefits are graduated

Other differences in social action on behalf of older persons may be briefly mentioned Great Britain and Sweden lead in health services specially directed to the aging France and Italy include older people in their general health programs. Similarly, Great Britain and Sweden are in the forefront with pioneering community services to enable older persons to remain in their own homes rather than to be cared for in institutions Sweden has first place in housing specially designed for the aging. The Netherlands, closely followed by the United Kingdom, has pioneered in provision of social clubs and groups for older people which are conspicuous by their absence in other countries.

The patterns of societal change and action affecting the aging have been the same or similar in these countries considered as representative of Western culture The details vary, owing more to the degree of industrialization than to differences in historical or cultural background, important though the latter may be, especially in Latin countries, such as France and Italy.

II Emerging Issues

The countries of Europe may be thought of as an unintended laboratory in social experimentation for inventions to insure the welfare of the aging. Of course no conclusive findings can be presented on the relative value of policies, programs, and projects. But different ways of meeting the same problem permit comparisons and raise issues on policies and programs

A statement of these emerging issues may be helpful at the present time. In preparation for the White House Conference on Aging we are now reviewing our philosophy and programs and projects in providing for the welfare of the aging and aged.

A. Employment of the Aging

A higher proportion of men 65 and over are employed in the United States than in any of the six European countries covered in our survey of Western culture Yet in all these nations the present percentage is less than that of past decades and is slated to decline further in the future What issues are suggested by our survey of European experience?

1 *Prolongation or shortening of the work life* as a policy for social action
2 *Compulsory, flexible,* or *gradual* retirement
3 *Optional retirement* as a modification of compulsory retirement
4 *Objective criteria* of aging versus *chronological age* as the determinant of retirement
5 *Employment by employer* or *self-employment* after retirement
6 *Full-time* versus *part-time employment* after retirement
7 *Employment of older or younger workers in periods of unemployment*
8 *Special provisions* to encourage employment of older workers, such as reservation jobs, work modifications, training centers, and inducements to employers
9. Legislation against *discrimination* in employment by age

B Income Maintenance

The widely different solutions to the problem of income maintenance of older persons by European countries disclose several important issues·

1 *Public versus private action* to insure basic minimum income maintenance has finally been decided in practically all countries of the world in favor of governmental control and administration The issue, however, is still open on the question of the responsibility for further increments of in-

come beyond the basic minimum Should these be obtained by action of the government, of the employer, of the union or of the individual?

2 *Pensions and assistance grants versus insurance* as the pattern of old age benefits continue to be debated Should the system of payments to older persons be paid out of general revenues or by contributions from insured persons and their employers? Some countries combine both patterns in their system of old age payments

3 *Source of funds* from insured persons employers and government varies widely Some countries rely on only one of these sources, others on all three and still others on two

4 *Flat-rate versus variable* contributions and benefits characterize different countries Flat rate contributions are typically associated with flat rate benefits But variable contributions may be tied to flat rate benefits Should the flat rate benefit be adopted as an exemplification of the principle of equity, all beneficiaries would share alike in the basic minimum support in old age

5 *The issue of adequacy of the benefit* covers a wide range of considerations Perhaps in no country does the basic benefit meet a minimum of budget requirements without supplementation from other sources such as savings homeownership aid from relatives and friends private pensions, etc Different countries supply different forms of additional payments generally under a means test either within the insurance or pension system or as assistance from other public funds Adequacy is also related to rising standards of living and to changes in the cost of living The issue here is whether adjustments should come through special legislation or should be changed automatically to meet changes in wage level or in the cost of living such as occur with rising production or with inflation Then too adequacy is concerned with provision for disability before eligibility to retirement and to the meeting of medical expenses including those of prolonged illness

6 *The age of eligibility for benefits* varies widely in different countries, although the median age is 65 for men and 60 for women Some countries have flexibility with reduced benefits with retirement at an earlier than normal age and increased benefits if the insured person retires later

7 *The retirement test of eligibility* for benefits is required only in some countries but not in others

C Housing and Community Services

In providing special housing and community services for the aging many European countries began earlier and have progressed further than the United States Their experience compared with ours is valuable in stating the issues

1 Remain in *home of middle years* or move to one suitable to the *later years*
2 *General* versus *special* housing for the aging
3 *Type of structure* as detached dwelling row houses apartments etc
4 *Towns for older people* versus dispersal in conventional community
5 *Communal* housing for *able bodied* or for *chronically ill*
6 *Rehabilitation* versus *custodial care* of the chronically ill
7 *Regulations and regimentation* versus *self government and planning* of activities by residents
8 *Institutional* versus *homelike climate* in communal housing
9 Care of older persons in *institutions* or in their *own homes* through community services
10 Medical services in the *home* versus in the *hospital*
11 Comparative *costs of independent* versus *communal and institutional housing*
12 Siting of institutions communities and smaller dwelling units in *urban* or *rural* areas
13 *General* versus *specialized and professional personnel* for care of the aging
14 *Financing of housing* by individuals and private agencies or by national and local governments

D Physical Health

The physical health of its citizens is of concern to each country in our survey of Western culture Certain issues arise of concern to all medical workers

1 The place of *the person and the family* in health care and prevention
2 Proportions of older people needing *permanent hospitalization* and other institutional or communal care
3 *Optimum number* of patients or residents in communal and institutional provision for the aging
4 *Custodial care* or *physical rehabilitation* of the handicapped
5 Equal emphasis upon *preventive* as upon *therapeutic* programs
6 Adoption of *good nutrition* for different stages in the life cycle
7 *Public education* in the health problems and needs of the aging
8 *Medical treatment at home* made possible by community services ('meals on wheels' homemakers nurses and visiting physicians) or all medical service in hospital
9 Hospitalization for the aging *curative, custodial, or pathological*
10 *Special geriatric unit* in general hospital versus *geriatric hospital*
11 Extension of the use of *day hospitals and consultative health centers*
12 *General practitioner* versus *geriatric specialist*

E Mental Health

The mental health of its population is a subject of increasing concern to all countries of Western culture The responsibility of care of mental patients is being transferred from the family to the government In comparing countries certain issues arise of interest to all workers in the field of mental hygiene in the United States

1 *Special provision* versus *general care of older mental patients* is still a debated issue
2 *Ratio of beds in mental hospital* varies from 2 per 100 000 population in Denmark to 4 per 100 000 population in Switzerland and Sweden To what extent will the newer *therapeutic methods* on the one hand and the apparent trend to increasing extramural care, on the other, affect the number to be treated in hospitals?
3 *Size of the mental hospital* tends to be much smaller in European countries than in the United States
4 *Voluntary admission as against legal commitment* seems to be the present trend in European countries, much more so than in the United States
5 *Alternative* or *supplements to hospital treatment by outpatient and day-center therapy*
6 *Classification of patients for treatment* in the community (short stay or long stay in the hospital)
7 *The optimum organization* of mental health services is already in the experimental and demonstration stage in some European countries

F Family Relationships

Before the industrial revolution a person's work and social life were usually carried on within the extended family and with its members This pattern of living still survives, as we have seen in certain rural areas of France Italy, the Netherlands, and West Germany Even when the extended family ceased to function as an economic unit, it still maintained a certain range of activities and responsibilities as a social unit How much and what these should be are issues in every country of Western culture

1 Restoration of *three generation family relations* versus acceptance of priority of the *nuclear family*
2 Reinforcement of *obligations of adult children* to support needy parents and to care for them in sickness versus development of *community services*
3 Relative desirability of grandparents living *with, near, or at a distance from* children and grandchildren
4 Promotion of conditions making for *mutual aid between generations* by governmental or private action
5 Social life of the aging *independent of* or *completely with* adult children
6 Grandparents as *disciplinarians* or *benevolent figures* to grandchildren

G Life beyond Family and Work

Compulsory retirement at either a fixed or a flexible age presented older persons and couples with an abundance of free time Only recently have gerontologists in Europe and the United States become con cerned with the issues involved in spending free time

1 Continuing *work at career or other occu pation* versus *volunteer activity* with some or similar meanings as work had
2 *Passive* versus *active* use of free time
3 *Informal social contacts* versus *member sh p in organi ed groups* for friendships sociability and meaningful activity
4 Social participation in *mixed* or *own age groups*
5 Segregation by locating in *retired* com munity versus integration by remaining in *normal* community
6 Leisure time objectives for *enjoyment and entertainment* or for *sociability health education and culture*
7 *Programs of preparation for retirement* to cover entire field or be limited to *financial aspects*
8 Leisure time activities and organizations to be planned *for* or *by* older persons
9 Sponsorship of activities and organizations by *older persons* or by *churches compa nies unions or welfare agencies*
10 Act vit es and organizations supported by *subsidies* or financed entirely or in part by *fees and dues*
11 *Governmental* or *private support* of ac t vities and organizations

The above issues emerging in seven areas of aging are real to persons confronted with decision making upon a particular policy project or practice But they fail to be impressive when viewed from the broad standpoint of social gerontology The reason is that they appear to be an ag gregate of individual issues

Yet each one of these concrete issues derives its significance from underlying basic issues which pose challenges to our thinking imagination and creativeness Seven of these basic issues are

1 Ways of establishing the autonomy and in dependence of older people in place of de pendency so as to release their energy in itiative and creativity
2 How to redefine roles and activities of older persons to have meaning in the modern world.
3 How to [illegible]

older people and to make necessary institu tional living more homelike
5 Methods of the development of measures of prevention and rehabilitation
6 How to enable the community to take ad vantage of the continuing contributions old er people can make
7 How government can best advance the wel fare of the aging without becoming a welfare state

III Values and Meanings of European Experience

The implications of European experience for the United States should be stated with considerable caution It is true of course that our country is part of Western culture Therefore whatever happens in Europe in the field of aging has meaning for us But the value to us of European experience must be viewed in terms not only of our likenesses but also of our differences

The first difference is in the *vast extent* of continental United States as compared with countries of western Europe The United States occupies nearly three million square miles as compared with less than half this area for western Europe excluding Communist governed countries *France*, with the largest area of the non Communis tic countries has a little over two hundred thousand square miles, or about one four teenth of the area of the United States.

A second difference is that of *density of population* The average population per *square* mile is a little over 200 for western Europe compared with less than 60 for the United States.

A third difference is the *higher mobility*

of the residents of the United States This refers not only to the greater frequency of residential change but also to the higher fluidity of the population facilitated by rapid transportation, particularly in travel by airplane and automobile Occupational and social mobility also proceeds at a more rapid rate

Fourth, the United States comprises fifty states, with the problem of the allocation of responsibility for the welfare of the aging to be assumed by the federal or the state government, whereas most European programs are operated by the federal or central government

Fifth, there is the greater *cultural diversity* of the United States which results from the more varied national and racial origins of the population and from regional differences

Sixth, the *historical and traditional backgrounds* are more deeply impressed upon thought and action in the older European countries than in the young United States

Seventh the *level of personal and national income* is lower in European countries than in the United States (see Table 10, p 473, in Part III)

Eighth *private initiative has been a traditional American characteristic with reliance upon individual families and voluntary* associations to take responsibility in dealing with problems

These and other differences should be taken into account in judging the meanings and values of European experience for the United States

These real differences between United States and European countries should not lead us to minimize the outstanding likenesses which have resulted directly or indirectly from industrialization One of these, which has not been mentioned until now, is present in all countries of Western culture, namely, a *mass mood* in the population to act *for the welfare of the aging*

In each of the countries of Western culture there exists a *social movement to promote* the welfare of the aging This social movement *is a response* to a powerful mass mood which impels people to respond as individuals uncritically and without deliberation, to proposals and programs in behalf of the aged and the aging

A brief analysis of the behavior of the individual in the mass will enable us to understand the mechanism of action of people as aggregates of individuals rather than as members of social groups, social classes and institutions Individuals in the mass act on the basis of what is common to them such as appetites, cravings, and vague and loosely organized feelings and sentiment These feelings and sentiments toward older people which are common to people of Western cultures are

1 *Filial sentiment* of adults to their parents
2 *Guilt feelings because of the* difficulty or inability in the urban environment of discharging the full traditional responsibility of the son or daughter toward aging parents This feeling includes social as well as financial obligation
3 *Humanitarian sentiment* and welfare ideology *This generalized sentiment* which is stronger in some countries than in others motivates action for the welfare of all disadvantaged groups including the aging
4 *Identification* of adults 20-64 with the aging This identification is a perception that sooner or later the young will also become *old Action for the benefit of the older generation* is therefore also an act of self interest of persons of all ages

Action on the basis of mass mood *is* uncritical and impulsive *It therefore becomes* necessary to attempt *to* find ways and *means of providing direction to the* expression of the mass mood for the welfare of *the aging Fortunately*, the survey of European experience provides leads to guide the thinking and leadership of gerontologists in different countries of Western culture

A Objectivity

The need for objectivity is imperative *for* gerontologists if the hazards of the blind leading the blind are to be avoided This survey of the experience of Western

culture should markedly contribute to this end

1 *Perspective* is gained by comparing the movement of social gerontology from country to country It is thereby possible to perceive American problems conditions, and programs in relation to the general progress of social gerontology in Western culture

2 *Projects and programs perceived in the context* of a culture provides another aspect of objectivity A given project can seldom be effectively transplanted unchanged from one country to another It will need to be adapted to the conditions of living of the new environment

3 *Clarification of issues* results from a comparison between countries of the thinking involved in establishing policies and programs for the welfare of the aging

B Critical Evaluation

The need for evaluation of policies, programs and

pean experience indicates that evaluation is in its infancy in Europe as in the United States Yet evaluation of policies, programs and projects is essential if applied social gerontology is to arrive at maturity

In all countries of Western culture including the United States many, if not most pioneering projects are known to the public through favorable accounts by their sponsors Such reports are far from being a valid basis for others to introduce such projects however worthy their objectives and however pressing the problems which they are designed to solve The cost of an evaluation of a promising pioneering project may be only a fraction of the funds likely to be wasted by attempts to copy an ill-conceived or inadequately reported project.

There are four types or levels of evaluation (1) self-evaluation, (2) opinions of experts on a project, (3) factual appraisal, and (4) experiment and control

1 *Self evaluation* ranges all the way from news releases designed to obtain favorable publicity to serious self study for the purpose of improving the operations of the project. The latter, if well done, is often of real value to the sponsoring agency It may also be helpful to other agencies considering the introduction of the project But, since it is geared to the needs of the sponsoring agency, it is likely to be less valuable to other organizations

2 *Opinions of experts* represent the evaluation most generally relied on at present for a judgment on the value of a project But experts differ They are influenced by differences in previous background and training and by the weight they give to certain policies and practices Then, too, the weight of expert opinion is likely to be inclined to favor existing standards, policies, and practices and to look askance at innovations which do not conform Therefore expert opinion may be an unreliable guide in assessing pioneering ventures

3 *Factual appraisal* is a survey of a project designed to gather and analyze the facts that are pertinent to an understanding and appraisal of the working of a project It utilizes the various available techniques, such as schedules, scales, inventories, and interviews adapted for the purposes of the project. Its findings are helpful alike to the sponsoring organization and to other agencies Its chief limitation is that it does not involve comparison with the operation of projects with the same or like purposes.

4 *Experimental and control projects* are the optimum type of evaluation The District Mental Health Service at Worthing described in Part II (Case Study No 6, pp 432–35) is an excellent example Here, two areas are compared with each other One of these, the experimental area, is the locus of the health service experiment. The control area has been sending patients to the same two hospitals but does not have the new service The object of the health service is to reduce hospital admissions by care in the home and in other facilities

of the residents of the United States This refers not only to the greater frequency of residential change but also to the higher fluidity of the population facilitated by rapid transportation, particularly in travel by airplane and automobile Occupational and social mobility also proceeds at a more rapid rate

Fourth, the United States comprises fifty states, with the problem of the allocation of responsibility for the welfare of the aging to be assumed by the federal or the state government, whereas most European programs are operated by the federal or central government

Fifth, there is the greater *cultural diversity* of the United States which results from the more varied national and racial origins of the population and from regional differences

Sixth, the *historical and traditional backgrounds* are more deeply impressed upon thought and action in the older European countries than in the young United States

Seventh, the *level of personal and national income* is lower in European countries than in the United States (see Table 10, p 473, in Part III)

Eighth, *private initiative* has been a traditional American characteristic, with reliance upon individual families and voluntary associations to take responsibility in dealing with problems

These and other differences should be taken into account in judging the meanings and values of European experience for the United States

These real differences between United States and European countries should not lead us to minimize the outstanding likenesses which have resulted directly or indirectly from industrialization One of these, which has not been mentioned until now, is present in all countries of Western culture, namely, a *mass mood* in the population to act for the welfare of the aging

In each of the countries of Western culture there exists a social movement to promote the welfare of the aging This social movement is a response to a powerful mass mood which impels people to respond as individuals, uncritically and without deliberation, to proposals and programs in behalf of the aged and the aging

A brief analysis of the behavior of the individual in the mass will enable us to understand the mechanism of action of people as aggregates of individuals rather than as members of social groups, social classes, and institutions Individuals in the mass act on the basis of what is common to them, such as appetites, cravings, and vague and loosely organized feelings and sentiment These feelings and sentiments toward older people which are common to people of Western cultures are

1 *Filial sentiment* of adults to their parents
2 *Guilt feelings* because of the difficulty or inability in the urban environment of discharging the full traditional responsibility of the son or daughter toward aging parents This feeling includes social as well as financial obligation
3 *Humanitarian sentiment* and welfare ideology This generalized sentiment which is stronger in some countries than in others motivates action for the welfare of all disadvantaged groups including the aging
4 *Identification* of adults 20–64 with the aging This identification is a perception that sooner or later the young will also become old Action for the benefit of the older generation is therefore also an act of self interest of persons of all ages

Action on the basis of mass mood is uncritical and impulsive It therefore becomes necessary to attempt to find ways and means of providing direction to the expression of the mass mood for the welfare of the aging Fortunately, the survey of European experience provides leads to guide the thinking and leadership of gerontologists in different countries of Western culture

A Objectivity

The need for objectivity is imperative for gerontologists if the hazards of the blind leading the blind are to be avoided This survey of the experience of Western

ing data and in the year for which data are available The multitude of variations is in part indicated by the number of footnotes for each table describing them It is to be expected that the reporting of data by countries and their comparability will continue to improve

Statistical yearbooks of different countries are also available which may provide other data or more detailed data than are obtained in the international yearbooks

B National Opinion Polls

Certain data that are not available through statistical yearbooks may be obtained by cross-cultural sample surveys The existing national opinion polls in various countries provide the mechanism. Two questions on retirement were recently asked by the International Research Associates, an association of national research institutes One was on the preferred age of retirement and the other on opinions about the adequacy of governmental old age pensions and assistance.

This organization may be willing from time to time to canvass their national polling samples on items of interest to social gerontology This co-operation will be helpful But a great advance would be made if inquiries were organized to exploit the full potentialities of this new research facility The cost would be much less expensive than would be required to set up research projects *de novo*

C Co operative Cross cultural Projects

Even more significant for research in social gerontology than the use of national opinion polls is the development of cross-cultural projects These can take place in two ways One method is to have a pioneering study in one country repeated in other countries The other and generally more effective way is the formal organization of a cross-cultural project by representatives from different countries

The Social Science Research Committee of the International Gerontological Association is now promoting such an undertaking As John E Anderson has pointed out in the preceding chapter, the Copenhagen Conference in 1956 of the European Division of this committee outlined a program which was later published as *The Need for Cross national Surveys of Old Age*

In August 1959, it held a second meeting in Italy to implement further planning and to draw up a research proposal It also inspired an investigation by Peter Townsend and Brian Rees, carried out in England in 1959, to pilot a future cross national survey of aging It has been published under the title, *The Personal, Family and Social Circumstances of Old People* (Townsend and Rees, 1959)

The European and American divisions of this committee sponsored a Seminar on Social Health of the Aging in Merino in July 1957, where plans were discussed for co-operative projects on employment, budgets family relations, and psychology of the aging

A second seminar is planned at the time of the Fifth International Congress of Gerontology in San Francisco in August, 1960 to continue discussions of cross cultural research and, if possible, to provide for planning of the research Appraisal of present research and the possibilities of cross cultural investigations are to be discussed in the areas of budgets and income, psychology, physical and mental rehabilitation, and retirement roles

D Research Personnel and Methods of Research

In the different countries of Western culture the basic conditions for valuable research in social gerontology exist Cross cultural studies are being planned Pilot studies have been made or are in prospect

Trained research personnel, who have had experience in research projects on the economic, psychological and social aspects of aging are available They are familiar

The result was a reduction of 59 per cent admissions to the two mental hospitals in the experimental district compared with an increase of 4 per cent in the control area.

The purpose of the control is to secure a project as identical or similar in its personnel and operations as is possible with the exception of the new variable introduced by the experimental project The measurable changes which take place in the experimental as compared with the control project are then a convincing proof of the values of the pioneering project

Experimental projects in the field of aging are conspicuous by their absence This successful demonstration in Worthing should stimulate further studies of this type in Europe, the United States, and other countries of Western culture The development of inquiries utilizing controls is likely to be a prominent characteristic of the forward movement of research in social gerontology

C Social Science Research

Evaluation studies are action research which focus on policies, programs projects, and practices They are not designed to yield basic knowledge about the aging process Yet on occasion they may make a limited contribution

What is imperatively needed to advance the new science of gerontology is a co ordinated program of basic research The closest approach to this objective is the continuing program of studies on aging and the care of the aging carried on by grants made by the Nuffield Foundation of England This statesman like program is described in detail in a document in Part II (Case Study No 13, pp 448–56) It discloses a remarkable record of achievement and suggests the possibilities in a program of social science research as over against an aggregate of individual projects

IV Cross cultural Comparisons

Social gerontology is a youthful science Research in the social aspects of aging is just beginning to get established The progress already made in western Europe and United States in the last 15 years provides a sound foundation for the future

Up to now studies have been confined to separate countries The bulk of research will continue to be carried on country by country But what are the conditions and the prospects for cross-cultural research? Such comparative studies will provide the essential body of theory and empirical findings to enable us to arrive at generalizations both (1) those that are universal in all societies and (2) those that are relative to economic, social and cultural differences among countries

The conditions favorable for cross national studies are in the process of coming into existence These are (1) comparable statistical data, (2) national opinion polls, and (3) co operative cross cultural projects

A Comparable Statistical Data

The United Nations now provides roughly comparable statistical data gathered from practically all the countries in the world It publishes annually a demographic yearbook and a statistical yearbook and a monthly report from its Statistical Office which presents a wealth of data on a wide range of topics

The World Health Organization and the International Labour Organization also publish yearbooks with statistical data respectively, in the fields of health and labor Several other organizations issue annual or occasional volumes containing data of direct or indirect interest to social gerontology

Selected tables derived from these sources are presented in Part III of this volume for nearly all European countries and a few other non European countries It is hoped that these data will be helpful to students interested in cross cultural studies of aging

The big difficulty in comparing statistics of different countries is the degree of comparability of the data on different items There are, naturally, differences in report-

PART TWO

Selected Case Studies

with the research of their colleagues in other countries and are personally acquainted through participation in seminars and conferences

Methods of research especially adopted to the study of aging are being developed A number of instruments and scales have been devised for the study of attitudes, roles and personal and social adjustment in aging and retirement

V Welfare Policy and the Autonomy of the Aging

Finally, this survey of social gerontology in countries of Western culture poses a basic and puzzling question of welfare policy Does provision by the government and by other organizations for the welfare of the aging mean regimentation resulting in a breakdown of the independence initiative, and autonomy of older people?

There is, as we have seen, in all European countries a growing tendency of older people to rely upon the government and on other economic and social organizations rather than upon themselves and upon their families and friends This shift is natural and perhaps inevitable in the new society in which we live Older individuals particularly are tending to demand more and more that society and the government do something for them, and the general public is more and more disposed to acquiesce

The humanitarian mood of the public toward older persons and other disadvantaged groups if misdirected could radically change the American way of life This disposition of the public to do something for the old and their tendency to accept it could undermine the initiative the autonomy, and the independency of older persons

The American way of life if it is to be preserved for both older persons and all of us, is not merely to help older persons but to help them to help themselves Every program and project designed to promote the welfare of older people particularly those originating in other countries, need to be thoroughly scrutinized to determine if it will result in the dependency of the aging or in strengthening their independence and freedom of action.

Up to the present time nearly all programs in behalf of the aging in the United States as well as in Europe are the products of the welfare mood, of expert opinion and of uncritical adoption of untested projects The time has come for critical evaluation of policies, programs, and projects and for reliance on basic research for the scientific knowledge of the capacities needs, and potentialities of aging people

REFERENCES AND BIBLIOGRAPHY

Great Britain General Register Office 1952 Census 1951 One per cent sample tables. London H M Stationery Office

[illegible]

ogy European Section 1958 The need for *cross national surveys of old age* report of a conference at Copenhagen October 19-23 1956. Ann Arbor Division of Gerontology University of Michigan

[illegible]

Kegan Paul

Shenfield Barbara E 1957 Social policies for old age a review of social provision for old age in Great Britain London *Routledge & Kegan Paul*

Tibbitts C (ed) 1959 Aging and social health in the United States and Europe Ann Arbor Division of Gerontology University of Michigan

Titmuss R. M 1959 Essays on the welfare state New Haven Conn Yale University *Press*

Townsend P and Rees B 1959 The personal family and social circumstances of old people London International Association of Gerontology Department of Social Science London University

U S Social Security Administration 1958 Social security programs throughout the world, 1958 Washington, D C Government Printing Office

Introduction

Fourteen case studies are presented in Part II The purpose of their inclusion is to supplement the survey and statistical data which were utilized in the comparisons of different countries in Part I

The case studies cannot be considered as representative They were rather selected to afford American readers a more intimate appreciation of significant aspects of aging in western European countries Some cases give a glimpse into the cultural context of the process of aging The majority of the cases, however, were selected as outstanding examples of European developments that merit special attention and consideration in this period when the American public is reviewing the present situation of the aging population and making plans for the future in preparation for the White House Conference on Aging to be held in January, 1961

The first two case studies present the chief provisions of the laws on old age and survivors' insurance and on medical care insurance in selected European countries They show the common pattern as well as wide variations in provisions for income maintenance of older people

The third case study is a pictorial representation of the outstanding features of housing design which embody the advanced thinking of Swedish gerontologists and architects It should stimulate the creativity and resourcefulness of planners in the United States and other countries to raise their sights on combining the functional and aesthetic aims in special housing for older people

The fourth case study gives an all round description of the organization and administration of a home-help service to promote the health and happiness of old people

The fifth case study presents the design and findings of a Swedish study of the mental health of a large Swedish rural population

The sixth case study describes the evaluation of the pioneering demonstration of meeting the problem of mental hospital overcrowding by the use of an intensive outpatient service

The seventh and eighth case studies give an insight into the family relations of older persons in two Latin European countries where familial ties are still very strong The first is an intimate view of extended family relations of an upper middle-class French family The second is a description of three generation family living in an Italian low income, rural district which is culturally backward

The ninth case study is a report of a social worker on the attitudes toward their adult children of residents of an old people's home

The tenth case study is a summary of the laws of six European countries on the duty of adult children to support needy parents

The eleventh and twelfth case studies describe the workings of social clubs for older persons in the two European countries—Great Britain and the Netherlands—where these have had their *greatest* developments

The thirteenth case study is that of the organized and continuous activity of the

1

Old Age and Invalidity Insurance

BELGIUM

Dates of Basic Laws

First law 1924 Old age and survivors' benefits currently governed by laws of 1955 (wage-earners), 1956 (independent workers), and 1957 (salaried employees), as amended Invalidity benefits currently governed by law of 1944, as amended

Coverage

Gainfully occupied persons generally, with separate systems for wage-earners, salaried employees (provisions very similar to those for wage earners), and independent workers (provisions different) Special systems for miners, seamen, railway employees and permanent public employees

Source of Funds

Insured person Wage earners, 4 25 per cent of wages (rising in 1960 and each 5 years by 0 25 per cent, to ultimate 5 75 per cent) Salaried employees, 4 25 per cent of salaries, with ceiling of 8000 francs[1] a month (10 000 francs from 1960) Independent workers 12,000 francs a year

Employer For wage-earners, 4 25 per cent of wages paid (rising to ultimate 5 75 per cent) For salaried employees, 6 per cent of salaries paid, with ceiling of 8000 francs a month (10 000 francs from 1960)

Government For wage-earners, annual subsidies, rising 40 million francs each year to maximum of 2 billion francs (1957 subsidy, 1320 million francs) For salaried employees and independent workers, subsidies of about 300 and 750 million francs a year, respectively All subsidies vary with cost-of living index

Above contributions finance old age and survivors' benefits only, invalidity benefits financed through health and maternity insurance

[1] 1 franc = 2 0 U.S. cents

Old Age Benefits

Amount Pension of 60 per cent (single person) or 75 per cent (married person) of average earnings during lifetime (earnings for each year revalued by coefficient reflecting cost-of living changes) Minimum pension single person, 18,700 francs a year, married person, 28,000 francs. For salaried employees, 36,000 and 45,000 francs, respectively Independent workers single person, 12,000 francs a year, married person, 18,000 francs Automatic adjustment of pensions awarded to cost-of living changes

Qualifying conditions Age 65 (men) or 60 (women), payable up to 5 years earlier, subject to reduction of 5 per cent per year (ages for unhealthy occupations, 60 and 55) Qualifying period 12 years of actual or credited employment in last 15 years (until 1960), 15 years in last 15 years (1960–69), all years since 1955 (1970–99), or 45 years for men and 40 for women (thereafter), periods of incapacity, involuntary unemployment, etc, credited (pension reduced proportionately, if qualifying period not satisfied) Retirement from gainful work, other than occasional work Pensions for aliens reduced 20 per cent, unless

Nuffield Foundation on aging and the care of the aged It is a signal example of a program of research, evaluation, and demonstration The studies and projects under its auspices have exemplified high standards of research design and competence and a lively interest both in basic research and in practical applications of knowledge for the welfare of aging persons

The last case study describes and evaluates the objectives and results of a study of old age pensioners carried on under the joint auspices of four university research institutes in West Germany

These fourteen case studies, considered individually, will give the reader some appreciation of significant aspects of European experience Taken together, they mirror high points of achievement by and for older people in the cultures of the Old World—cultures not widely different from our own

ried couple to 9 per cent of the average gross income of all breadwinners is payable irrespective of income or means, adjusted each year for cost-of living changes, 1957 annual pensions, 680 crowns for single person and 1020 crowns for couple National pensions and supplements also payable subject to income test and half yearly cost of living adjustments as shown in Table 1 (1957 rates in crowns a year)

Reduction for other income follows a sliding scale starting at 60 crowns for each 100 crowns of income over specified exempted amounts (in Copenhagen, exemptions of 2600 and 1800 crowns from capital allowed couple and single person respectively, other income exemptions, one-third higher)

Qualifying conditions For minimum pension, age 67, no contribution or income test For national pension and supplements, age 65 for men, 60 for women (to be increased to 66 and 61, respectively in April, 1959, and to 67 and 62 in April, 1961) National pension and supplements subject to income test

Invalidity Benefits

Amount Invalidity pension and supplements, subject to income test and half yearly cost of living adjustments, are as shown in Table 2 (1957 rates, in crowns a year)

TABLE 1

DENMARK NATIONAL PENSION AND SUPPLEMENTS ACCORDING TO PLACE OF RESIDENCE
(1957 Rates in Crowns per Year)

	Copenhagen		Provincial Towns		Rural Districts	
	Couple	Single	Couple	Single	Couple	Single
Basic pension	5064	3360	4800	3228	4404	2952
Marriage supplement (if only one spouse entitled to pension)		564		504		444
Postponement supplement						
To age 70 (single woman 65)	504	336	480	324	432	288
To age 72 (single woman 67)	756	492	708	480	648	432
Old age supplement (at age 80)	2 6	180	264	180	240	168
Supplement for surviving spouse		432		408		372
Supplement for each child under 15	924	924	804	804	684	684

TABLE 2

DENMARK INVALIDITY PENSION AND SUPPLEMENTS ACCORDING TO PLACE OF RESIDENCE
(1957 Rates in Crowns per Year)

	Copenhagen		Provisional Towns		Rural Districts	
	Couple	Single	Couple	Single	Couple	Single
Basic pension	064	3360	4800	3278	4404	2952
Marriage supplement (if only one spouse entitled to pension)		564		504		444
Invalidity supplement	960	480	960	480	960	480
Supplement for each child under 15	924	924	804	804	684	684
Assistance supplement (in need of constant attendance or blind)	1296	864	1224	816	1116	744
Helplessness supplement (in need of constant nursing)	2160	1440	2034	1356	1854	1236

reciprocal agreement. Pensions not payable abroad, unless reciprocal agreement.

Invalidity Benefits

Amount Pension of 60 per cent of earnings (continuation of sickness benefit under health insurance), reduced to 40 per cent after 6 months for pensioners without dependent, unless constant attendance required Maximum 100 francs a day for family heads and pensioners needing constant attendance, 68 francs for others Automatic adjustment of pensions awarded to cost of living changes

Qualifying conditions Under age 65 (men) or 60 (women) Loss of 67 per cent of earning capacity in usual occupation Six months of coverage, including 120 days of actual work (if under 25, 3 months and 60 days), and coverage during last quarter preceding onset of incapacity

Survivors' Benefits

Amount Widow's pension of 30 per cent of highest average earnings of deceased (earnings for each year revalued by coefficient reflecting cost of living changes), minimum pension 14,000 francs a year Widow of independent worker 9000 francs a year Automatic adjustment of pensions awarded to cost of living changes Lump sum (if ineligible for pension) 1 year's pension

Qualifying conditions Widow, age 45, caring for child or 67 per cent incapacitated Husband insured or pensioner during last 12 months before death (if not, reduced pension payable proportionate to years of employment between age 20, or 1926 if later, and death) Married 1 year, and not remarried (lump sum of 2 years' pension on remarriage) Not payable if gainfully employed, unless occasionally only Pensions for aliens reduced 20 per cent, unless reciprocal agreement Pension not payable abroad, unless reciprocal agreement.

Administration

The Ministry of Labor and Social Welfare has general supervision National Social Security Office, in Ministry, collects contributions and distributes to national agencies administering benefits National Retirement and Survivors Pension Fund administers benefits, managed by administrator representing Ministry, assisted by joint employee-employer council National Sickness and Invalidity Insurance Fund administers invalidity pensions (together with sickness benefits) Solidarity and Guarantee Fund administers pensions for independent workers, under supervision of Ministry of Middle Classes

DENMARK

Dates of Basic Laws

First law 1891 Currently governed by Social Insurance Act as amended on October 2, 1956

Coverage

All Danish citizens not otherwise entitled to pensions from public funds May be modified by reciprocal treaty

Source of Funds

Insured persons Old age national pension tax of 1 per cent of income subject to income tax No contribution payable if national pension tax for person with dependents less than 40 crowns (kroner)[2] a year, or for a single person less than 25 crowns Invalidity, 21 60 crowns a year

Employer Old age, none Invalidity, 14 25 crowns a year

Government Balance of cost, from general revenues (estimated government share of national pension costs about 85 per cent)

Old Age Benefits

Amount Minimum pension equal for single persons to 6 per cent and for a mar-

[2] 1 crown = 14 48 U.S. cents

ned couple to 9 per cent of the average gross income of all breadwinners is payable irrespective of income or means, adjusted each year for cost-of living changes, 1957 annual pensions, 680 crowns for single person and 1020 crowns for couple National pensions and supplements also payable subject to income test and half yearly cost of living adjustments, as shown in Table 1 (1957 rates, in crowns a year)

Reduction for other income follows a sliding scale starting at 60 crowns for each 100 crowns of income over specified exempted amounts (in Copenhagen, exemptions of 2600 and 1800 crowns from capital allowed couple and single person respectively, other income exemptions, one-third higher)

Qualifying conditions For minimum pension, age 67, no contribution or income test For national pension and supplements, age 65 for men, 60 for women (to be increased to 66 and 61, respectively in April, 1959, and to 67 and 62 in April, 1961) National pension and supplements subject to income test

Invalidity Benefits

Amount Invalidity pension and supplements, subject to income test and half yearly cost-of living adjustments, are as shown in Table 2 (*1957 rates, in crowns a year*)

TABLE 1

DENMARK NATIONAL PENSION AND SUPPLEMENTS ACCORDING TO PLACE OF RESIDENCE
(1957 Rates in Crowns per Year)

	Copenhagen		Provincial Towns		Rural Districts	
	Couple	Single	Couple	Single	Couple	Single
Basic pension	5064	3360	4800	3228	4404	2952
Marriage supplement (if only one spouse entitled to pension)		564		504		444
Postponement supplement						
To age 70 (single woman 63)	504	336	480	324	432	288
To age 72 (single woman 67)	756	492	708	480	648	432
Old age supplement (at age 80)	276	180	264	180	240	168
Supplement for surviving spouse		432		408		372
Supplement for each child under 15	924	924	804	804	684	684

TABLE 2

DENMARK INVALIDITY PENSION AND SUPPLEMENTS ACCORDING TO PLACE OF RESIDENCE
(1957 Rates in Crowns per Year)

	Copenhagen		Provisional Towns		Rural Districts	
	Couple	Single	Couple	Single	Couple	Single
Basic pension	5064	3360	4800	3228	4404	2952
Marriage supplement (if only one spouse entitled to pension)		564		504		444
Invalidity supplement	960	480	960	480	960	480
Supplement for each child under 15	924	924	804	804	684	684
Assistance supplement (in need of constant attendance or blind)	1296	864	1224	816	1116	744
Helplessness supplement (in need of constant nursing)	2160	1440	2034	1356	1854	1236

Qualifying conditions Inability to earn one third of earnings of person with similar training and skill in locality Income deductions and exemptions same as for old age membership in sick club and of good character

Survivors' Benefits

None

Administration

The Ministry for Social Affairs has general supervision Old age pension claims adjudicated by social affairs committees of communes and pensions disbursed by commune of residence Administration of invalidity insurance interlocked with health insurance administration as to eligibility, income, etc Invalidity Insurance Court national body of five members appointed by the Minister, determines right to invalidity benefit

FINLAND

Dates of Basic Laws

First law 1937 (old age and invalidity insurance), assistance introduced 1952 Current insurance and assistance governed by law of June 8 1956 effective January 1957

Coverage

All residents age 16–64 (Subject to modification by reciprocal treaty)

Source of Funds

Insured persons 1½ per cent of income starting in 1958 (no contribution ceiling)

Employer 1¼ per cent of total payroll starting in 1958

Government National and local governments pay cost of assistance Local share varies from 10 per cent to 30 per cent of assistance costs according to capacity to pay, resurvey of local share each 3 years Average national share of assistance costs approximately 77 per cent National government also pays cost of basic pensions not financed by contributions and interest.

Old Age Benefits

Amount Basic benefit of 24 000 marks (markka)[3] a year payable regardless of other income or employment In addition assistance payments of 72 000 63 000 or 54 000 marks a year, according to cost of living zone, assistance payments reduced by 50 per cent of amount by which other income exceeds 34 000 24 000, or 17 000 marks a year (according to cost of living zone) For aged couples benefits are 160 per cent of above and amounts of outside income permitted for assistance are correspondingly increased Assistance pensions increased 10 per cent for each child under 16

Persons deferring receipt of pension receive additional 12 5 per cent of basic pension for each year of postponement (maximum 5 years)

Benefits and income limits automatically changed with changes in cost of living index

Qualifying conditions Age 65 No requirement of insurance coverage or retirement Single woman aged 63 and over may receive old age assistance Residence and citizenship required for assistance (subject to modification by reciprocal treaty)

Property in excess of 2 million marks (single person) or 3 million marks (couple) taken into account for assumed income purposes in granting assistance

Invalidity Benefits

Amount Basic pension and assistance amounts same as for old age with same income test

Qualifying conditions Age 16 and 64 years of age Permanently incapable of maintaining self by work suited to strength and qualifications

[3] 1 mark = 0 434 U S cent

Survivors' Benefits

No pension Funeral benefit equal to 1 year's basic pension, 24 000 marks payable in following order spouse, children under age 16 other heirs parents, or person providing funeral

Administration

The National Pension Institute is major administrative agency, with district offices throughout country ordinarily coinciding with commune borders, representative appointed by Institute in charge of each district office Governing body of Institute named by the President Local pension committees (instead of Institute's district offices) determine income of persons claiming old age assistance with local representative of Institute acting as chairman of committee Payments made monthly

FRANCE

Dates of Basic Laws

First law 1910 Non agricultural system currently governed by law of 1945 as amended agricultural system by law of 1935 as amended National Solidarity Fund created by law of 1956 Assistance legislation dates from 1941

Coverage

Non-agricultural system All industrial commercial domestic and other non agricultural employees

Agricultural system Employees over 14 in agriculture and forestry Special systems for miners railway employees seamen public employees and self employed persons

Source of Funds

Insured person 6 per cent of wages up to 528 000 francs[4] a year partly for health and maternity insurance (agriculture, 5 per cent of wages)

Employer 10 per cent of payroll excluding wages over 528,000 francs a year, partly for health and maternity insurance (agriculture, 5 per cent of payroll)

Government None for insurance Various 1956 increases in general taxes on income, alcohol automobiles, inheritances, etc, earmarked to finance National Solidarity Fund Government pays entire cost of ordinary assistance

Old Age Benefits

Amount Standard benefit, 20 per cent of average wages in last 10 years (wage ceiling 528 000 francs a year, wages in earlier years revalued) Increment of 4 per cent [illegible]

[illegible] 40 per cent of average wages, at 70, 60 per cent Reduced benefit, 1/30 of standard benefit times years of insurance Special benefit, 50 per cent of joint contributions paid in Lump sum, 1 year's special benefit Minimum annual benefit, 65 800 francs Supplement of 50 per cent for dependent spouse, and 10 per cent if 3 children reared Supplement from National Solidarity Fund of 31 200 francs a year also payable to all qualified low income beneficiaries Formerly employed workers not entitled to old age benefit and having limited income receive allowance of 68 640–72,380 francs a year according to residence, plus 50 per cent for spouse over 65 and 10 per cent if 3 children reared (Assistance with income test available to destitute aged persons not entitled to other benefit or allowance)

Qualifying conditions Standard benefit, age 60 and 30 years of insurance Reduced benefit, age 60 and 15 years of insurance Special benefit, age 65 and 5 years of insurance Lump sum, age 65 and less than 5 years of insurance National Solidarity Fund supplement age 65, or 60 if unfit for work, and annual income below 201 000 francs for single person or 258 000 if couple Allowance for formerly employed worker, age 65, or 60 if unfit for work, French citizenship 15 years of employment after

[4] 1 franc = 0 24 U.S cent.

age 50, and annual income including allowance below 201,000 francs for single person or 258,000 if couple Retirement not required

Invalidity Benefits

Amount Partial invalid, 30 per cent of average wages in last 10 years (wage ceiling 528,000 francs a year, wages in earlier years revalued), total invalid, 40 per cent of average wages, total invalid needing constant attendance, 54 per cent of wages, 10 per cent supplement if 3 children reared Minimum benefit, 72,380 francs a year

Qualifying conditions Under age 60 (replaced by old age benefit at 60) Partial invalid, loss of two thirds of earning capacity of normal worker of same category in region, total invalid, loss of all capacity to carry on any occupation Entry into insurance 12 months before invalidity, and 480 hours of employment in last 12 months or 120 hours in last 3 months Benefit suspended if earning capacity rises above 50 per cent and reduced if benefit plus earnings exceed normal wages

Survivors' Benefits

Amount Widow or widower, 50 per cent of benefit of deceased spouse, plus 10 per cent supplement if 3 children reared minimum benefit, 36 190 francs a year No periodical benefit for other survivors Lump sum benefit 90 times average daily wages of insured maximum, 132,000 francs (lump-sum benefit under agricultural system 25 times average monthly contribution)

Qualifying conditions Widow or widower, age 65, or age 60 and unfit for work, dependent on deceased, married before deceased attained 60 or, if survivor's benefit payable before 65 2 years of marriage Deceased must have satisfied insurance requirements for invalidity or old age benefit or been recipient of allowance for formerly employed worker Lump sum benefit, 60 hours of insured employment or certified unemployment in quarter preceding death, payable to dependent spouse descendants, or ascendants

Administration

The Ministry of Labor and Social Security has general supervision with Superior Social Security Council as advisory body, General Social Security Directorate within Ministry prepares regulations, decrees, circulars, etc, for applying law National, regional, and primary (district) social security funds, under elected tripartite or bipartite governing bodies, administer program, regional old age and regional invalidity funds are main administrative organizations, with primary funds collecting contributions and National Fund handling financing (Agricultural system Ministry of Agriculture, general supervision Mutual Agricultural Social Insurance Fund in each department [province], with elected bipartite governing body, administers program including coverage contributions, and benefits, co-ordinated by two central agricultural funds for invalidity or old age benefits)

WEST GERMANY

Dates of Basic Laws

First law 1889 Currently governed by National Insurance Code of 1911, as extensively amended by Wage-Earners' and Salaried Employees' Pension Laws of February 23, 1957

Coverage

All wage earners and all salaried employees earning not more than DM 15 000[5] a year (separate system for each) Voluntary coverage for persons with 60 months of insurance in 10 years Special systems for miners, self employed craftsmen and civil servants

Source of Funds

Insured person 7 per cent of wages, excluding those above twice average taxable

[5] 1 Deutsche mark = 23.81 U.S cents

earnings in last 3 years (1957 ceiling DM 750 a month) No contribution if wages 10 per cent or less of ceiling

Employer 7 per cent of payroll, excluding wages above twice average taxable earnings in last 3 years, 14 per cent of payroll for employees whose wages are 10 per cent or less of ceiling

Government Substantial lump sum subsidy, fixed each year and varied with changes in average taxable wages In 1957 equaled about one third of cost of wage earners' system and one-fifth of that of salaried employees' system

Old Age Benefits

Amount 1 5 per cent of individual's "assessed wages" times years of insurance ("Assessed wages" computed by applying to average taxable earnings of all workers in last 3 years the percentage that individual's wages were of average wages of all insured persons throughout his contribution period national average taxable earnings in 1954–56 DM 357 a month "Years of insurance" include credited periods of incapacity, unemployment or schooling after 15) Supplement for each child 10 per cent of average taxable earnings of all workers in last 3 years (DM 36 a month in 1957) Outstanding pensions to be adjusted by special legislation to future changes in average taxable earnings on basis of status of pension finance and national economy

Qualifying conditions Age 65 (women at 60 if worked 10 of last 20 years and have retired also man or woman at 60 if unemployed 1 full year and remaining unemployed) 180 months of contribution (including credited periods of military service or internment) Retirement not required except for pensions before age 65 Not payable to non Germans living abroad.

Invalidity Benefits

Amount General disability benefit, 1 5 per cent and occupational invalidity benefit, 1.0 per cent, of individual's assessed wages times years of insurance (see "Old Age Benefits" for explanation of "assessed wages" and "years of insurance") If invalid under 55, and had 36 months of contributions in last 5 years or contributions in one-half of months since entry into insurance, benefit computed as if contributions paid until 1955 Supplement for each child, 10 per cent of average taxable earnings of all workers Medical care and rehabilitation services provided

Qualifying conditions General invalidity benefit, inability to exercise any regular gainful activity, occupational invalidity benefit, reduction of earning capacity below 50 per cent of that of normal person with similar training and ability, 60 months of contribution (including credited periods of military service or internment) Not payable to non Germans living abroad

Survivors' Benefits

Amount Widow or dependent widower, 100 per cent of deceased's actual or potential benefit for first 3 months after death, thereafter, if over 45 invalid or caring for child, 60 per cent of deceased's general invalidity benefit otherwise, 60 per cent of occupational invalidity benefit Each half orphan 10 per cent and each full orphan 20 per cent, of deceased's actual or potential benefit, plus regular children's supplements (10 per cent of average taxable earnings) Maximum for all survivors' benefits, 100 per cent of deceased's pension

Qualifying conditions Widow, not remarried (final lump sum of 5 years' benefit paid on remarriage) Widower, dependent on deceased and not remarried Orphan, under 18 (under 25 if student and unmarried), or invalid, 60 months of contribution Not payable to non Germans living abroad except to orphans when person responsible for care lives abroad

Administration

Federal Ministry of Labor has general supervision State insurance offices, one in each state administer wage-earners' system Federal Salaried Employees Insurance

Office administers salaried workers' system Contributions collected by sickness insurance agencies

GREAT BRITAIN

Dates of Basic Laws

Old age and survivors' insurance, first law 1925 Invalidity insurance, first law 1911 Currently governed by National Insurance Act 1946, as amended

The National Insurance Act, 1959, does not change the amount or payment of the standard flat old age pension The major change is the provision for the payment of wage related additional benefits based on the payment of graduated contributions *The new provisions do not apply to the one* third of the total working population now covered by pension plans, but employers may apply to bring their employees under its terms

Coverage

Residents age 15–65 (men) or 15–60 (women) Insurance not compulsory for *self employed and non employed persons* with incomes below £156 a year, nor for married women

Source of Funds

Insured person Flat rate weekly contribution as follows male employee, *7s 5d* male self employed, *9s 3d*, and male non employed, *7s 4d*, female employee, *6s* female self employed, *7s 10d*, and female non employed, *5s 10d* (Lower rates if under age 18)

Employer Flat rate weekly contributions as follows each male employee, *6s 2d*, each female employee *5s 1d* (Lower rates for employees under 18)

Government Flat rate weekly contributions as follows each male employee and non employed, *1s 10d*, male self employed *2s 6d*, female employees and non employed, *1s 10d*, female self employed, *2s 2d* (Lower rates for persons under 18)

Also, if required, £325,000,000 between 1955 and 1960

NOTE —Above contributions also finance other national insurance benefits (e g, sickness maternity, unemployment), old age invalidity and survivor benefits represent about two thirds of national insurance costs

Old Age Benefits

Amount Single person *40s* a week couple if both insured, *80s*, couple if wife not insured, *65s* Allowance for first child under 16, *11s 6d* a week, and for each subsequent child, *3s 6d* Pension increased *1s 6d* a week for each twenty five weekly contributions paid during first 5 years after pensionable age Reduced for men under 70 and women under 65 by *6d* a week for each *1s* of earnings between *50s* and *70s* and by *1s* for earnings over *70s*

Qualifying conditions Age 65 for men 60 for women, 156 weekly contributions paid and for full pension, average of 50 paid or credited each year, proportionately reduced benefit if fewer than 50 contributions annually, with minimum of 13 contributions annually (contributions are credited in case of unemployment or sickness) Retirement required unless claimant 5 years past pensionable age Residence in country not required, but pension amount not increased after leaving country unless reciprocal agreement provides otherwise

Invalidity Benefits

Amount Single person *40s* a week, *25s* weekly supplement for adult dependent, *11s 6d* for first child and *3s 6d* for each other child (these are sickness benefits which are paid without limit on duration if qualifying conditions are met, there is no invalidity benefit as such) (Lower rates for married women and youths under 18)

Qualifying conditions 156 weekly employee or self employed contributions paid and, for full benefit, 50 weekly contributions paid or credited in previous contribution year Incapacity for work by reason

of specific disease or bodily or mental disablement. Must reside in country or in another with which there is a reciprocal agreement

Survivors' Benefits

Amount Widow's allowance for first 13 weeks 55*s* a week, plus 16*s* 6*d* for first child and 8*s* 6*d* for each other child Thereafter, widowed mother's allowance of 56*s* 6*d* a week plus 8*s* 6*d* for each child after the first, or if no child a widow's pension of 40*s* a week Allowance of 18*s* a week paid to guardian of full orphan Funeral benefit of from £6 to £20

Qualifying conditions For widows' benefits 156 weekly contributions paid and for full benefit average of 50 paid or credited each year Widow's allowance paid for 13 weeks regardless of age Widowed mother's allowance payable if child of school age, but reduced 6*d* a week for each shilling of earnings of 60–80*s* and shilling for shilling if earnings exceed 80*s* Widow's pension normally payable only if marriage of 3 years duration and widow was age 50 at husband's death If mother over 40 when children attain school leaving age widowed mother's allowance becomes a permanent widow's pension For guardian's allowances one parent must have been insured but no contribution is required

Administration

The Ministry of Pensions and National Insurance administers program through regional and loc [illegible]
[illegible]
employers and workers friendly societies and the [illegible]

ITALY

Dates of Basic Laws

First law 1919 Currently governed by Act of April 4 1952

Coverage

Employed persons aged 14–59 (women, 14–54) Includes agricultural workers Separate systems for seamen and public employees

Source of Funds

Insured person 2 4 per cent of earnings

Employer 6 6 per cent of payroll, plus small wage-class contributions equal to approximately 0 2 per cent of payroll Flat rate contributions for agriculture and domestic service

Government None currently, law states that government will eventually pay 25 per cent of cost

Old Age Benefits

Amount Men 45 times 45 per cent of first 1500 lire[6] of contributions paid, 33 per cent of next 1500 lire, and 20 per cent of other contributions, increased by 6–40 per cent for postponement of pension from 1 to 5 years Women, 45 times 35 per cent of first 1500 lire of contributions paid, 26 per cent of next 1500 lire, and 20 per cent of other contributions, increased by 3–62 per cent for postponement of pension from 1 to 10 years 10 per cent supplement for each dependent child. Thirteenth monthly benefit paid each December Minimum annual benefit, 45 000 lire if under 65 or 65 000 lire if over 65, maximum benefit, 80 per cent of average wages in last 5 years

Qualifying conditions Age 60 for men and 55 for women 15 years since first entry into insurance, plus specified minimum total contributions (different for wage-earners and salaried employees and varying in agriculture by sex and occupational category, increased value is assigned contributions paid before 1948, periods of military service sickness, and pregnancy credited) From 1962, 15 years of contributions will be required, with reduced benefit after 10 years (requirement increases 1 year at time from 1952 to 15 years in 1962)

[6] 1 lira = 0 16 U.S cent

Invalidity Benefits

Amount Same as for old age, with minimum of 65 000 lire a year Hospital or other care provided for prevention or cure of invalidity

Qualifying conditions Permanent reduction of earning capacity in suitable occupation by two-thirds for wage earner and one half for salaried employee, 5 years since first entry into insurance, plus specified minimum total contributions (different for wage earners and salaried employees and varying in agriculture by sex and occupational category), 1 year of contribution in last 5 years From 1962, 5 years of contributions will be required (gradual increase from 1 year of contributions in 1952) Benefit may be withheld if medical treatment refused

Survivors' Benefits

Amount Widow or incapacitated widower, 50 per cent of old age pension of deceased each half orphan, 20 per cent of pension, each full orphan 30 per cent of pension, one parent or grandparent, 15 per cent of pension, two or more parents or grandparents, 30 per cent of pension divided equally Minimum, 45 000 lire a year

Qualifying conditions Contribution requirements as for invalidity pension Children under 18 or invalid and not gainfully occupied Parents and grandparents entitled only if no spouse or orphan's benefit payable, age 65, and receiving no other pension

Administration

The Ministry of Labor and Social Welfare has general supervision National Social Insurance Institute, with branches throughout the country, administers program, managed by tripartite governing body

NETHERLANDS

Dates of Basic Laws

First law 1913 Currently governed by Act of May 31, 1956

Coverage

All permanent residents age 15-64

Source of Funds

Insured persons 6 75 per cent of net income up to 6900 guilders[7] a year No contribution payable if annual income below 1500 for single person or 2100 guilders for married person Income ceiling varies with changes in wage index

Employer None

Government Contributions on behalf of low income person and any eventual deficit

Old Age Benefits

Amount Full pension, 846 guilders for single person and 1404 guilders for aged couple, with automatic half year adjustment for each 3 per cent change in wage index Decrements of 1-2 per cent for each year of non-contribution

Qualifying conditions Age 65 though amount for couple paid irrespective of age of wife Regular contribution each year until age 65 required for full pension No retirement requirement Persons over age 15 when act enacted must have 6 years of residence after attaining age 59 to qualify Pensions payable to persons age 65 or over at start of Act if residents at least 6 years since age 59

Invalidity Benefits

[Information not yet available on present status of older invalidity provisions]

Survivors' Benefits

Widow over 65 receives old age benefit Widow of deceased pensioner under 65 continues to receive benefit for 6 months only

Administration

The Ministry of Social Affairs and Public Health has general supervision Direct administration by Social Insurance Bank,

[7] 1 guilder = 26.32 U S cents

which decides and pays claims, industrial associations may be assigned certain administrative functions Contributions collected by Government Revenue Office

NORWAY

Dates of Basic Laws

First law 1936 (in force, as amended until end of 1958 provisions not charted below) Law of 1957 in effect from January 1, 1959

Coverage

All resident citizens aged 18–69 Special systems for seamen forestry workers and government workers

Source of Funds

Contribution amounts based on estimated annual expenditure under program Initial amounts based on estimated 1959 expenditure of 570 million crowns are as follows

Insured person If income exceeds 6000 crowns (kroner)[3] a year full premium (initially 250 crowns a year) if income is 4000–6000 crowns a year, two thirds of full premium (167 crowns) if income is 2000–4000 crowns a year one-third of full premium (83 crowns) No contribution if income not in excess of 2000 crowns a year

Employer 60 per cent of employees contributions.

Government National government amount equal to 15 per cent of contributions paid by insured persons Communes amount equal to 20 per cent of contributions paid by insured persons

Old Age Benefits

Amount Single person 2208 crowns a year couple 3312 crowns a year, increased by 600 crowns for each child under 18 Pension supplement may be granted by commune subject to income test formula for reducing supplement because of outside income is to add 150 per cent of basic pension to any other income and to reduce amount of supplement by half the sum of the two factors

Qualifying conditions Age 70, and either (1) citizenship with continuous residence during 5 years preceding claim or (2), if not a citizen residence for 15 years after age 20 with 5 years continuous residence immediately prior to claim Work on Norwegian ship deemed equivalent to residence Wife eligible at age 60 if husband meets above qualifications Invalid husband formerly dependent on wife, also eligible at age 60 if wife meets above qualifications

Invalidity Benefits

None

Survivors' Benefits

Amount Widow (or disabled widower) of pensioner entitled to same amount as deceased pensioner Additional pension subject to income test may also be provided by commune

Qualifying condition Age 60

Administration

The Department of Social Affairs has general supervision Pension Board in Department administers national aspects of program and supervises operations Claims handled at local level by communal pension committee, composed of chairman and vice chairman named by governor of province on recommendation of communal council and of five members appointed by communal council

SWEDEN

Dates of Basic Laws

First law 1913 Currently governed by law of 1946, as amended

The three new laws of May 14, 1959, establish a system of supplementary pensions in addition to the present universal flat "national pension" The system of supplementary benefits will be financed exclusively by

[3] 1 crown = 14 US cents

employers. Their contributions are effective as of 1960, and benefits are payable 3 years later. Ultimately, the supplementary pension will equal 2 per cent of taxable earnings times years of coverage up to 30 years.

Coverage

All Swedish citizens aged 18–66.

Source of Funds

Insured persons: 2.5 per cent of income subject to income tax; maximum annual contribution, 250 crowns (kronor).[9] No tax if income is under 1200 crowns annually. (Contributions cover about 30 per cent of cost.)

Employer: None.

Government: National government pays approximately 55 per cent of cost of program from general revenue, and communes pay approximately 15 per cent of cost.

Old Age Benefits

Amount: Basic amounts and supplements in 1956 were as shown in Table 3 (in crowns per year).

TABLE 3

SWEDEN: NATIONAL PENSION AND SUPPLEMENTS ACCORDING TO MARITAL STATUS
(1956 Rates in Crowns per Year)

	Single Person	Aged Couple
Basic amount	1700	2720
Fixed supplement	200	320
Cost-of-living supplement	300	480
Total	2200	3520

About half the pensioners also receive a housing supplement varying with commune of residence and income. A housewife's benefit is also payable, subject to income test, if pensioner's wife is age 60–66 and if the marriage is of at least 5 years' duration; maximum, 1760 crowns a year.

[9] 1 crown = 19.33 U.S. cents.

Two additional allowances are payable if the pensioner has children—the regular family allowance of 290 crowns a year per child and the special children's allowance for persons with low incomes of 600 crowns a year per child.

Qualifying conditions: Age 67; Swedish citizen, or national of country having reciprocal treaty with Sweden and specified minimum residence in Sweden. (No relationship between contributions and benefit eligibility, and no income test for basic benefits.)

Housing supplement and housewife's benefits paid in full if outside income does not exceed 1000 crowns for single person and 1500 crowns for couple; reduced by one-third for income of 1001–1400 crowns; by two thirds for income over 1400 crowns.

Invalidity Benefits

Amount: Flat amount of 200 crowns a year, plus invalidity supplements subject to income test, bringing the total maximum rates to the same total as for the old age pension (including cost of living and other supplements). Housing supplements and housewife's benefits are also payable as for old age.

Blind persons receive an extra allowance of 1000 crowns plus the basic 200 crowns without income test.

A sickness allowance of the same amount as the permanent disability benefit is payable in case of temporary but long continued disability.

Qualifying conditions: Age 16–66. Permanently incapable of self support in work corresponding to experience and training. Housing and housewife's benefits are subject to income tests the same as for old age pensioners. Blindness supplement is paid without income test to persons who have become blind before reaching age 60.

For the sickness allowance, disablement must exist as for invalidity, lasting 6 months, but not deemed permanent. This benefit is granted for specific periods in advance.

urvivors' Benefits

Amount Widow's benefit is maximum of ... income test
s
al
ar
00
and spe...
crowns a year are payable to full orphans and half-orphans, full orphans receive a special allowance, subject to reduction for outside income

Qualifying conditions Widow, age 55 at time of husband s death or caring for child under 12, marriage must have been of at least 5 years' duration The income test is the same as for the housing supplement for a single person (above) Children's benefits are the same as for old age (above)

Administration

The Ministry of Social Affairs has general supervision The National Pension Board administers program nationally Local pension committees receive and process claims Contributions collected with national income taxes

UNION OF SOVIET SOCIALIST REPUBLICS

Dates of Basic Laws

First law 1922 Currently governed by law of July 14, 1956

Coverage

Wage and salary workers and students in higher specialized schools Important exclusions members of collective farms and producers' co-operatives Special systems for scientists, writers, composers, architects, and other groups

Source of Funds

Proportionate share of following combined social security contribution, which also covers cash benefits under health and maternity insurance and family allowances

Insured person None

Employer Percentage of anticipated payroll, budgeted at different rate for each industry, and varying from about 3 7 to 10 7 per cent of payroll

Government Usually pays employer contribution, though not directly, because industry and other business is nationalized. Act provides that "the State will pay pensions through funds provided in the U.S.S R State budget, including funds under the budget for State social insurance "

Old Age Benefits

Amount Benefits (in rubles)[10] vary by wage class and work category, as shown in Table 4 Increased by 10 per cent of pen-

TABLE 4

U.S S R. OLD AGE PENSION AS PERCENTAGE OF MONTHLY WAGES BY WAGE AND TYPE OF EMPLOYMENT

Average Monthly Wage (Rubles)	Pension as Percentage of Wages	
	Normal Employment	Unhealthy and Underground Employment
To 350 (inclusive)	100	100
350–500	85	90
500–600	75	80
600–800	65	70
800–1000	55	60
1001 and over	50	55

sion for 15 years' uninterrupted work and, if not employed, by 10 per cent for 1 dependent unable to work and by 15 per cent for two or more Average wages computed over last 12 months or, at option of claimant over any 5 consecutive years during last 10 years Minimum pension, 300 rubles a month, maximum, 1200 rubles Pension reduced to 150 rubles or to 50 per cent of pension in case of employees in unhealthy

[10] 1 ruble = 2 6 U.S cents free world rate, or about 10 U.S cents official rate

or underground work, if pensioner continues to work

Qualifying conditions Normal employment for men, age 60 with 25 years' work, for women, age 55 with 20 years' work Employment under "difficult" conditions for men, age 55 with 25 years' work, for women, age 50 with 20 years' work Unhealthy or underground work · for men, age 50 with 20 years' work, for women, age 45 with 16 years' work At least half of time must have been in special employment to qualify for special conditions Proportionately reduced pensions paid to persons reaching pensionable age while actively employed, with at least 5 years' work but not enough for a full pension, minimum reduced pension, one-fourth of full pension

Invalidity Benefits

Amount Complete invalidism if needing constant attendance, 85 per cent of average monthly wages up to 500 rubles, plus 10 per cent of higher wages, with 300-ruble minimum and 900 ruble maximum, otherwise, 65 per cent of wages up to 450 rubles, plus 10 per cent of higher wages, with 230-ruble minimum and 600 ruble maximum, 10 per cent supplement for one dependent or 15 per cent for two or more dependents, 10 per cent supplement for 10–14 years of continuous employment or 15 per cent for 15 years, and 15 per cent supplement for needed attendance, with maximum supplement of 30 per cent

Partial invalidism 45 per cent of average monthly wages up to 400 rubles, plus 10 per cent of additional wages, with 160 ruble minimum and 400 ruble maximum

Workers employed under "difficult" conditions receive above basic percentages but applicable up to 500 rubles, with 15 per cent of higher wages, for those in unhealthy or underground work, percentages apply to wages of up to 600 rubles, with 20 per cent of higher wages

Qualifying conditions Complete invalidism, incapacity for any work, partial invalidism, incapacity for usual work Sliding scale of required years of employment rising from 2 years for men and 1 year for women aged 20–23 to 20 years for men and 15 years for women over age 61, fewer years, rising from 1 to 14 years, for those in unhealthy or underground employment, no minimum employment period for invalids under age 20 Proportionally reduced pension payable to complete invalids with insufficient years of employment, with minimum of 25 per cent of full pension Wages plus pension of employed partial invalids may not exceed previous earnings, except that at least 50 per cent of pension always payable

Survivors' Benefits

Amount One surviving dependent, 45 per cent of average monthly wages up to 400 rubles, plus 10 per cent of higher wages, with 160 ruble minimum and 400-ruble maximum, two dependents, 65 per cent of wages up to 450 rubles, plus 10 per cent of higher wages, with 230 ruble minimum and 600 ruble maximum, three or more dependents, 85 per cent of wages up to 500 rubles, plus 10 per cent of higher wages, with 300 ruble minimum and 900 ruble maximum If survivors are full orphans, basic percentages above changed to 65, 90, and 100 for one, two, or three or more survivors

If deceased employed under "difficult" conditions, basic percentages apply up to 500 rubles, with 15 per cent of higher wages if employed in unhealthy or underground work, percentages apply to wages of up to 600 rubles, with 20 per cent of higher wages

Ten per cent supplement if deceased had 10–14 years of continuous employment or 15 per cent for 15 years

Qualifying conditions Eligible survivors include widow age 55, invalid or caring for child under 8, widower age 60 or invalid, children, brothers, sisters, or grandchildren under 16 (under 18 if student), or invalids, and parents age 60, invalid, or caring for child under 8 Must have been dependent

on deceased Sliding scale of required years of employment of deceased, rising from 2 years for men and 1 year for women aged 20–23 to 20 years for men and 15 years for women over age 61, fewer years, rising from 1 to 14 years for workers in unhealthy or underground employment Proportionally reduced pensions if insufficient years of employment, with 25 per cent minimum

Administration

All Union Central Council of Trade Unions has general supervision Regional and district trade union committees have direct administration and decision of claims Factory, shop, and local committees do preparatory work on claims Department of Social Assistance has supervision over non-working pensioners

2

Pensioners and Medical-Care Insurance in Eleven European Countries

INTRODUCTION

Patterns of medical care for persons receiving old age benefits of one type or another in eleven different countries reveal considerable variation The following brief summary attempts to show whether or not such pensioners are covered for medical benefits, what they contribute, and what medical benefits they receive The countries considered are Belgium, Denmark, Finland, France, West Germany, Great Britain, Italy, the Netherlands, Norway, Sweden, and the Union of Soviet Socialist Republics Their systems include old age insurance programs, universal pensions, and old age assistance

BELGIUM

Employed persons must join a mutual benefit society or the regional office of an official auxiliary fund Pensioners are covered for medical benefits Contributions from insured persons and employer are supplemented by a subsidy equal to 16 per cent of the above contributions

Sickness benefits for insured persons provide 75 per cent of the cost of specialist care, surgery, hospitalization, laboratory services, and appliances and part of the cost of general medical care, medicines, dental care, and nursing

DENMARK

Denmark's major benefit for aged persons is a pension based on the individual's income and resources

Like other members of the population who have modest incomes, the Danish old age pensioner may choose between active and passive membership in a sick club Active members receive free medical care from physicians, free hospital services, and three-fourths of the cost of medicines designated as necessary They may, if the rules of their sick club permit, obtain specialist treatment, dental care, baths and massage, and certain other services

The pensioner who is an active member pays, like other such members, about 4 crowns a month for medical care only The fees vary somewhat among the clubs At this contribution level there is a cash benefit of 40 ore a day [1] The pensioner may choose to become insured for a somewhat higher cash benefit than the minimum, but not for more than 1 crown a day Duration of cash benefit for pensioners is 13 weeks, or half the usual maximum duration of such payment However, the provision of any cash sickness benefit is unusual, since most health insurance programs that make provision for pensioners under health insurance concern themselves only with services

FINLAND

Finland has a pension payment composed partly of universal benefit and partly of a flat rate based on inquiry into the resources of the claimant The latter may be three times as large as the former

[1] 100 öre = 1 crown (14 83 U.S cents)

Finland has no health insurance except non subsidized programs which are con ducted in some cases by mutual societies and in others by insurance companies

Old age pensioners it appears have no special position in relation to any medical service benefits

FRANCE

In France benefits for aged persons are provided through the social insurance sys tem. The regular insurance benefit is sup-plemented—if the pensioner s income is small—by a substantial flat rate payment from the National Solidarity Fund which is financed from various earmarked taxes

Employer worker contributions totaling 16 per cent of earnings finance both health and pens ons insurance The agencies of administration—local regional and na tional—are all part of the general system of social insurance for persons in non ag ricultural occupations Local agencies (*cais ses primaires*) administer short term bene fits regional agencies (*caisses regionales*) the long term payments

Old age pensioners and their wives and dependent children continue to be covered for medical benefits under the health in surance provisions after the individual s coverage as an active worker has ceased The pens oner pays no contribution

The benefits consist of an 80 per cent re fund according to fee schedule of medical costs and of medicines and the provision of the full cost of hospital care either in a public hospital or at a rate not to exceed that of a public hospital

WEST GERMANY

In the German Federal Republic old age benefits are payable under an insurance system.

Pen oners are insured for medical care including those under the systems for wage-earners salaried employees and miners.

The contributions are paid by the insur ing institution at rates fixed by the Federal M n ter of Labor Neither the health in surance funds nor the pension establish-ments have a direct influence in determining the level of contributions for pensioners

The benefits consist of medical care in cluding services of a physician, medicines, and hospitalization

GREAT BRITAIN

British retirement benefits are paid un der the National Insurance System

Medical care which is free at the time the service is provided is available sep-arately under the National Health Service to all persons whatever their age whether insured or not

ITALY

Italian benefits for the aged are paid under an insurance system.

Pensioners and their dependents—includ ing wife, children, young brothers and sis ters and aged parents—are eligible for medical care under health insurance This is a fairly recent development, the program of pensioners benefits having started in November 1955, under legislation of Au gust 4, 1955

The cost is not paid by the pensioner but is met from the joint employer worker con [illegible] 1956, the rate of contribu tion has been 11 60 per cent of earnings, payable two-thirds by the employer and one-third by the insured wage-earner or salary worker

Medical care for Italian pensioners con sists of general and specialized services (the latter including obstetrical treatment), medicines and hospitalization Moreover, a decree of December, 1956 listed various special diseases of old age, which are treated without time limit.

NETHERLANDS

Dutch old age benefits are quasi univer sal but are subject to a decrement for years of non-contribution.

The situation respecting health insurance services for pensioners has changed more than once in the past few years Currently, as from January 1, 1957, there is a similarity to the Danish program in that pensioners are not subject to compulsory health insurance but may join a sickness fund voluntarily if not receiving income in excess of 3530 guilders a year

Financial support for the benefits to pensioners is derived from the insured, the government, and the sick funds The pensioner pays either 0 55 guilder a week, or 1 10 guilders, according to whether his income is less or greater than 2520 guilders annually This meets from a quarter to one half the cost, the remainder being financed half by government grant and half by the fund operating the compulsory health insurance program

The medical benefits are general and specialist services, medicines, hospitalization, and dental treatment.

NORWAY

Norway has changed from pensions based on the means test to universal pensions, the change occurred on January 1, 1959

The amendments to health insurance introduced by the Sickness Insurance Act of March, 1956, provided that "every person who is resident in Norway shall be insured under this act" There is no reference to pensioners by way either of emphasizing their compulsory affiliation or of making an exception When pensions were based on the income test, the local government where the pensioner lived paid the health insurance contribution for coverage

For pensions paid irrespective of income or insurance status, the normal position for the pensioner would appear to be that of any other old person The medical-care premium, payable quarterly at the rate of 0 90 crown a week, is compulsory There is also, for most non-employed persons, an optional added premium for obtaining cash benefit (not considered further, since cash benefits are not under review) It would seem that under the new Norwegian pension act the pensioner himself would pay the premium, but no information has been received on this point

The medical benefits include doctor's care, often through reimbursement by the sick club according to fee schedule, with the insurance program paying from two thirds to three fourths of the cost and the patient the difference Also among the benefits are the full cost of hospitalization (surgery being a hospital service) in a public hospital, without time limit, essential medicines, physiotherapy, and limited dental care such as extractions and other work necessary for the individual's health

SWEDEN

In Sweden benefits for aged persons are provided by a program of universal pensions

Insurance for medical care is compulsory for all Swedish citizens over 16 and living in Sweden

No health insurance contribution is paid by persons over age 67, or by national pensioners

The medical service benefits are a 75 per cent refund of costs of physician's treatment and a refund of hospital costs at the rate for treatment in a public ward There is partial payment of the cost of medicines, but some life-saving medicines are free

UNION OF SOVIET SOCIALIST REPUBLICS

Benefits to aged persons are paid on an insurance basis

Since medical services are provided outside the insurance system to all persons without cost except in the case of medicines or appliances, pensioners appear to have no special position in the U S S R As members of the community they are entitled to medical care

3

Swedish Housing Design[1]

SWEDISH OLD PEOPLE'S HOMES

Swed hh f th

t

nc

cale They are designed for home type living and to reduce institutionalism

is much used in rich warm tones and designs reflect the traditional Swedish motifs Simplicity without institutional sterility is achieved through the use of good textiles in rugs, draperies, and upholstery and of well designed furniture *The open fireplaces* bright pieces of copper, and flowering plants add the warm touches of home

The lovely homes shown here were designed by one of Sweden's most talented architects, Bo Boustedt of Kungalv, Sweden

[1] This account was prepared by Wilma Donahue Chairman Division of Gerontology Institute for Human Adjustment University of Michigan Ann Arbor

Exterior of Starrkarr home for aged people fits the landscape

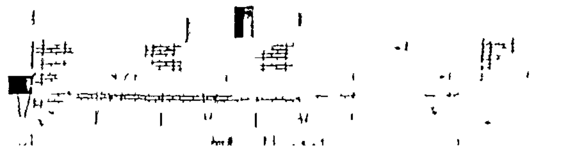


A RESTRAINED TOUCH OF AI

:arrk:rr

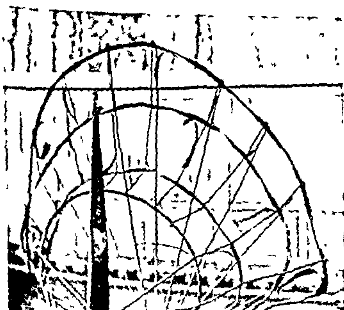
le of Ryssby Home for thirty six aged persons







Sculpture in pool in the yard of Ranneslov Home for thirty aged persons



Modern motif, by sculptor R Denman, Gothenburg, at Munkedal Home for forty aged persons



A RESTRAINED TOUCH OF ART

A RESTRAINED TOUCH OF ART

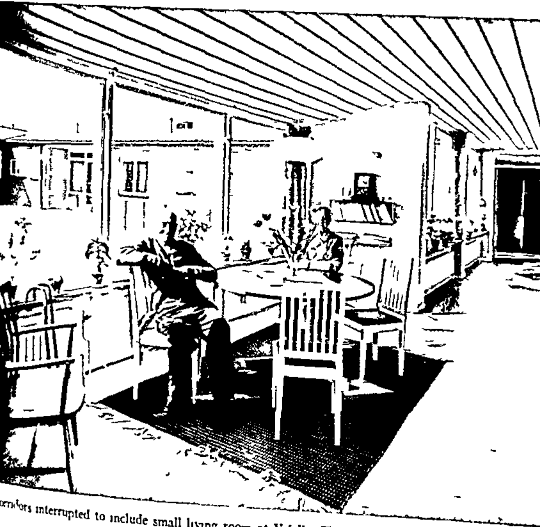
Cross-lighted, broken corridors at Vetlanda Home for thirty-three aged persons



HALLS DESIGNED TO OFFSET INSTITUTIONAL EFFEC

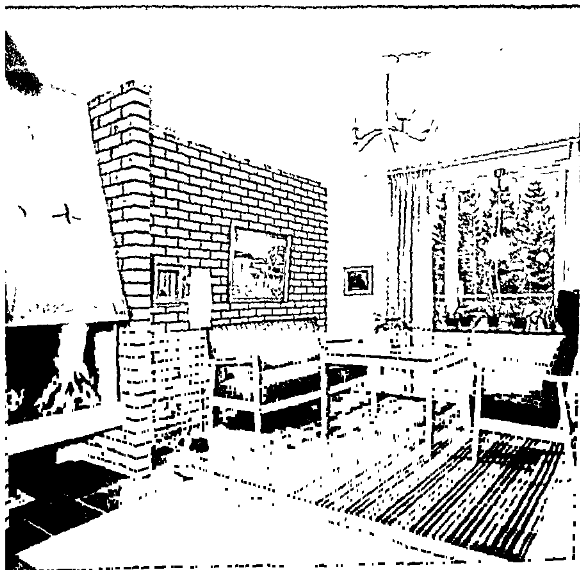


Halls ope
daylight
comforta
sitting ro
Sandared
thirty age



Corridors interrupted to include small living room at Vifolka Home for forty two aged persons

Open fireplace in the living room of Vara Home for twenty-six old persons





The two rooms composing a little assembly hall at Vetlanda Home for thirty-three old persons



Living room adjacent to small dining room at Eksjo Home for fifty old people

SMALL DINING ROOMS FOR COMPANIONSHIP



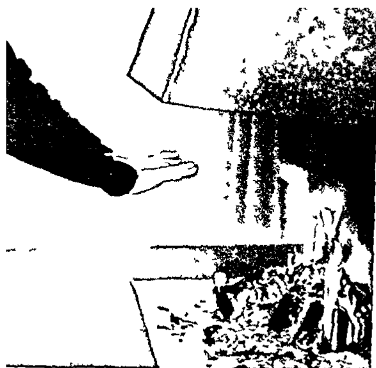
the two dining rooms at Vetlanda Home for thirty three old persons

A PRIVATE ROOM FOR EACH

Using her own furniture at Eksjö—one of fifty resident rooms

Furniture specially designed for the elderly at Vetlanda—single room





THE ENJOYMENT OF HOME

Enjoying the warmth of the open fire at Gislaved Home for thirty aged persons



g his native skill
edal Home for forty
sons



Coffee kitchen center of resident life at Eksjo Home for fifty aged people



THE ENJOYMENT OF HOME

Enjoying the warmth of the open fire at Gislaved Home for thirty aged persons



ıg his native skill
.edal Home for forty
'sons

and the whole relationship assumes a distinct family atmosphere One helper has married the old man she visited

There appear to be a few advantages, particularly in cases of sickness, in employing helpers of 60 years of age or more, they have a closer knowledge of the process of aging and usually have a good deal of spare time and can put in extra hours at short notice or can stay longer than the agreed upon period in order to chat.

We have used several forms of newspaper advertisement to obtain helpers When the applicants call, we listen to their reasons for applying, in the majority of cases it is because they like old people or like caring for someone and have perhaps lost their own parents Economic reasons are seldom of primary importance At the office we all agree that we cannot judge the applicant at this interview Several times we have reluctantly engaged a helper simply because we had no alternative at the time and have found her to be excellent with old people Only in a few cases is it apparent at the initial interview that an applicant would be unsuitable for the work.

In some cases it is obvious that the applicant would not fit in happily with a rough or dirty old person, and others would enjoy trying to improve the lot of 'some poor old soul" Points like this are noted at the interview

We go through our cards to try to find a suitable helper for each old person Great care is taken in selection, and the value of the scheme is enhanced if the old person and the helper live near each other

FINANCIAL MATTERS

We pay our helpers 1*s* 9*d* per hour plus bus fare The old people pay 2*s* 6*d* per hour and some of them receive the total cost from the National Assistance Board Many battles are waged on this point. It frequently occurs that when the old person receives the extra money from the National Assistance Board, he decides to do without the help or to have 2 hours instead of 4, etc The skill and tenacity of old people on matters of finance are constant tests of our own intelligence

In some cases sons or daughters pay the cost—one old lady pays the helper 2*s* for her 4 hours' help, and the son and the daughter in law pay the balance direct to the office The old lady does not know this, since she thinks 6*d* an hour good money A number of old people pay the full amount themselves and are very grateful for the service

We receive a grant from the Dispensary Committee (a local charity), which covers insurance stamps, additional hours worked in emergencies, cases where payment is not recovered, and bonus of 10*s* where a particularly dirty job is undertaken

TRAINING

Training is done on an individual basis There is such variety among our helpers that I would hesitate to try group talks, nor do I think that such talks would be appealing

Each helper calls at the office at least once every week to pay in the money she has collected from her old people and to collect her own wages On these occasions we discuss the old people [illegible] with the old people Other problems (like the reluctance of an old man to change his shirt or to get up in cold weather, or the old lady who spends 9*s* a week on her two cats out of her National Assistance and then cannot pay the helper) are also talked over By regularly discussing the problems, the helpers develop great skill in dealing with old people Their techniques vary from threats to cease visiting to constant praise and flattery, and at the bottom of it all is a genuine affection

type of help needed and the number of visits necessary After talking the matter over with the old person and agreeing on the number of hours of help each week, we ask the selected helper to call so that the actual days and times of the visits can be fixed We find this initial friendly visit very much worthwhile Before the helper goes, we discuss the case and point out likely difficulties This preliminary visit was arranged after an old lady told me that she had not slept all night because she had been wondering what "the helper would be like" It avoids a great deal of anxiety and often lays the foundation for a good relationship When the inquiry comes from a hospital, the helper visits the old person there whenever possible and sometimes goes to get them when they are leaving Similarly, when an old person is receiving help under this scheme and has to go to the hospital, we nearly always find that the helper is left with the key of the house or room (a very great privilege) and that she makes regular visits to the hospital These visits are voluntary

On the first day that the helper starts her duties we make a visit later in the day to check that all is well This is essential, since it is at this stage that arrangements tend to go wrong For instance, the old person may have changed her mind about having the help, or has decided she cannot afford to pay for help, etc.—then we have to start explaining all over again Because having help in their homes—perhaps for the first time in their lives—is a big step for old people (it is a reminder of the process of aging), we accept it that installing a helper and establishing a good relationship is a delicate business and will not be achieved without some difficulties Once the helper has visited two or three times, we experience little difficulty, but, if a satisfactory relationship is not established we replace the helper Sometimes the request comes from the helper herself

We visit 91 old people every week, of these, 52 live alone and range in age from 60 to 92 The majority are in the 75 and over group, and 9 are over 85 Last year, according to their time sheets, our helpers worked 9640 hours In actual fact many more hours were worked, but these were done voluntarily

The homes vary a good deal and range from dark, smelly rooms in condemned property to spic and span, well preserved homes Some of our most likable old people are to be found in the former group

Frequently when we are first called in, we have to put in as many as 4 hours' help daily, particularly in cases of sickness, but we reduce this as quickly as possible We encourage the old people to take as active an interest as possible because we believe that this is good for them, and for economic reasons we arrange the minimum number of hours' help Many old people can manage with one visit of 2 or 3 hours of help weekly Others need daily visits

THE ACTUAL WORK

The helpers undertake anything that is necessary, such as cleaning, shopping cooking, washing clothes, washing the old person, cutting toenails These are the jobs they do when actually employed, and the list is considerably increased if those things they do voluntarily are included shopping expeditions visits to the sea hot dinners on Sundays, the new cakes they take, the pensions they collect, and occasionally the gin or cider they call for—these and many other kindnesses could be enumerated

We employ 38 part time helpers, their ages range from 30 to 70, and 17 of these are over 60 They vary in social background from a tough old Irish lady whose language is formidable to smartly dressed young wives who are interested in social work They vary as much as the old people they help Many have children, and the work has a special appeal as the times of visiting can be arranged when the children are at school and can, when necessary, be altered by agreement with the old people Sometimes the helpers with their children make friendly visits to their old people,



F-1 ?en center of resident l fe at Eksjo Home for fifty aged people



THE ENJOYMENT OF HOME

Enjoying the warmth of the open fire at Gislaved Home for thirty aged persons



Following his native skill at Munkedal Home for forty aged persons

4

Old People's Housework Scheme[1]

It was four years ago that the Exeter Council of Social Service received a grant to set up a home-help scheme for elderly people, and a very modest start was made with the appointment of one helper and the preparation of a supply of forms for completion by old people requiring help.

The first results were not promising and for 6 weeks I put off the painful experience of reviewing the progress of the scheme. Our first applications were received and the forms sent out; of these forms, however, the first two were never returned, and several others came back incomplete.

In spite of these setbacks the helper did actually visit a few homes, and I was satisfied that a satisfactory standard of cleanliness was being achieved. I was disappointed on my first two visits to the old people when they did not express appreciation of their cleaner and tidier homes, but I did not feel the full import of the situation until an old man told me in no uncertain terms what he thought. His sugar had been in the same place for 20 years and he was not going to move it from the mantelpiece for anybody!

When the next application was received, I decided to make a visit myself instead of mailing a form. I found the old man in a sadly neglected state but in spite of the filth and the fleas he was very happy. He agreed that the floor "could do with a sweep." He was 64, independent and intelligent, and it was apparent that *if any* improvements were to be made, they could be accomplished only with the old man taking an active part. I visited him several times, and we became friends and discussed the possibility of someone helping him. I arranged for a carefully selected helper to call to see him. They seemed to like each other, and soon she was visiting regularly and many improvements were made. This helper remained with the old man until she retired 2 years later. During this time they had many rows, but the friendship remained firm. I was staggered to find that in the rehabilitation of this old man it had been necessary to contact no less than sixteen different departments and individuals.

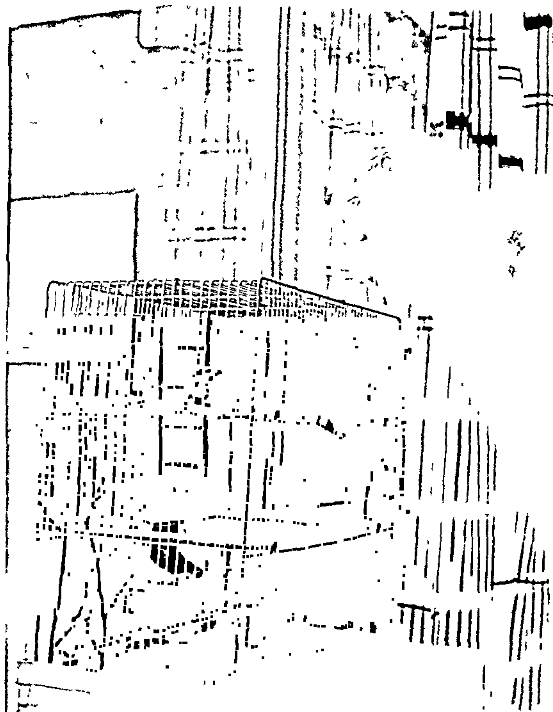
From this experience it was clear that housework alone was not sufficient to insure the maximum well-being of our old people. Henceforward the forms were scrapped and the term "health (physical and mental) and happiness" took priority over the word "cleanliness."

HOW THE SCHEME WORKS

Applications for help are received from local hospitals when an old person is ready to be discharged; from doctors, health visitors and old people themselves, relatives and friends of old people; the National Assistance Board, the Welfare Department, and sanitary inspectors.

We obtain as much information as possible when the application is made, including the name of the doctor, relationship with neighbors, church, etc., and we arrange to visit the old person to discuss the

[1] This story, written by Helen L. Slater, appeared in Social Service 28 (Winter 1954): 15-31. Minor changes have been made in the text.



A morning conversation at Frandefors Home for thirty six aged persons

and the whole relationship assumes a distinct family atmosphere One helper has married the old man she visited

There appear to be a few advantages, particularly in cases of sickness, in employing helpers of 60 years of age or more, they have a closer knowledge of the process of aging and usually have a good deal of spare time and can put in extra hours at short notice or can stay longer than the agreed upon period in order to chat

We have used several forms of newspaper advertisement to obtain helpers When the applicants call, we listen to their reasons for applying, in the majority of cases it is because they like old people or like caring for someone and have perhaps lost their own parents Economic reasons are seldom of primary importance At the office we all agree that we cannot judge the applicant at this interview Several times we have reluctantly engaged a helper simply because we had no alternative at the time and have found her to be excellent with old people Only in a few cases is it apparent at the initial interview that an applicant would be unsuitable for the work

In some cases it is obvious that the applicant would not fit in happily with a [illegible] are noted at the interview

We go through our cards to try to find a suitable helper for each old person Great care is taken in selection, and the value of the scheme is enhanced if the old person and the helper live near each other

FINANCIAL MATTERS

We pay our helpers 1s 9d per hour plus bus fare. The old people pay 2s 6d per hour and some of them receive the total cost from the National Assistance Board Many battles are waged on this point. It frequently occurs that, when the old person receives the extra money from the National Assistance Board, he decides to do without the help or to have 2 hours instead of 4, etc. The skill and tenacity of old people on matters of finance are constant tests of our own intelligence

In some cases sons or daughters pay the cost—one old lady pays the helper 2s for her 4 hours' help, and the son and the daughter in law pay the balance direct to the office The old lady does not know this, since she thinks 6d an hour good money A number of old people pay the full amount themselves and are very grateful for the service

We receive a grant from the Dispensary Committee (a local charity), which covers insurance stamps, additional hours worked in emergencies, cases where payment is not recovered, and bonus of 10s where a particularly dirty job is undertaken

TRAINING

Training is done on an individual basis There is such variety among our helpers that I would hesitate to try group talks, nor do I think that such talks would be appealing

Each helper calls at the office at least once every week to pay in the money she has collected from her old people and to collect her own wages On these occasions we discuss the old people she visits If additional services, such as chiropody treatment or mobile meals, seem to be desirable, we ask the helper to discuss the matter with the old people. Other problems (like the reluctance of an old man to change his shirt or to get up in cold weather, or the old lady who spends 9s a week on her two cats out of her National Assistance and then cannot [illegible] over By [illegible] the helpe[illegible] with old people Their techniques vary from threats to cease visiting to constant praise and flattery and at the bottom of it all is a genuine affection

type of help needed and the number of visits necessary After talking the matter over with the old person and agreeing on the number of hours of help each week, we ask the selected helper to call so that the actual days and times of the visits can be fixed We find this initial friendly visit very much worthwhile Before the helper goes, we discuss the case and point out likely difficulties This preliminary visit was arranged after an old lady told me that she had not slept all night because she had been wondering what "the helper would be like" It avoids a great deal of anxiety and often lays the foundation for a good relationship When the inquiry comes from a hospital, the helper visits the old person there whenever possible and sometimes goes to get them when they are leaving Similarly, when an old person is receiving help under this scheme and has to go to the hospital, we nearly always find that the helper is left with the key of the house or room (a very great privilege) and that she makes regular visits to the hospital These visits are voluntary

On the first day that the helper starts her duties we make a visit later in the day to check that all is well This is essential, since it is at this stage that arrangements tend to go wrong For instance, the old person may have changed her mind about having the help, or has decided she cannot afford to pay for help, etc.—then we have to start explaining all over again Because having help in their homes—perhaps for the first time in their lives—is a big step for old people (it is a reminder of the process of aging), we accept it that installing a helper and establishing a good relationship is a delicate business and will not be achieved without some difficulties Once the helper has visited two or three times, we experience little difficulty, but, if a satisfactory relationship is not established, we replace the helper Sometimes the request comes from the helper herself

We visit 91 old people every week, of these, 52 live alone and range in age from 60 to 92 The majority are in the 75 and over group, and 9 are over 85 Last year, according to their time sheets, our helpers worked 9640 hours In actual fact many more hours were worked, but these were done voluntarily

The homes vary a good deal and range from dark, smelly rooms in condemned property to spic-and span, well preserved homes Some of our most likable old people are to be found in the former group

Frequently when we are first called in, we have to put in as many as 4 hours' help daily, particularly in cases of sickness, but we reduce this as quickly as possible We encourage the old people to take as active an interest as possible because we believe that this is good for them, and for economic reasons we arrange the minimum number of hours' help Many old people can manage with one visit of 2 or 3 hours of help weekly Others need daily visits

THE ACTUAL WORK

The helpers undertake anything that is necessary, such as cleaning, shopping, cooking, washing clothes, washing the old person, cutting toenails These are the jobs they do when actually employed, and the list is considerably increased if those things they do voluntarily are included shopping expeditions, visits to the sea, hot dinners on Sundays, the new cakes they take, the pensions they collect, and occasionally the gin or cider they call for—these and many other kindnesses could be enumerated

We employ 38 part-time helpers, their ages range from 30 to 70, and 17 of these are over 60 They vary in social background from a tough old Irish lady whose language is formidable to smartly dressed young wives who are interested in social work They vary as much as the old people they help Many have children, and the work has a special appeal as the times of visiting can be arranged when the children are at school and can, when necessary, be altered by agreement with the old people Sometimes the helpers with their children make friendly visits to their old people,

and the whole relationship assumes a distinct family atmosphere One helper has married the old man she visited

There appear to be a few advantages, particularly in cases of sickness, in employing helpers of 60 years of age or more, they have a closer knowledge of the process of aging and usually have a good deal of spare time and can put in extra hours at short notice or can stay longer than the agreed upon period in order to chat

We have used several forms of newspaper advertisement to obtain helpers When the applicants call, we listen to their reasons for applying, in the majority of cases it is because they like old people or like caring for someone and have perhaps lost their own parents Economic reasons are seldom of primary importance At the office we all agree that we cannot judge the applicant at this interview Several times we have reluctantly engaged a helper simply because we had no alternative at the time and have found her to be excellent with old people Only in a few cases is it apparent at the initial interview that an applicant would be unsuitable for the work.

In some cases it is obvious that the applicant would not fit in happily with a rough or dirty old person, and others would enjoy trying to improve the lot of 'some poor old soul' Points like this are noted at the interview

We go through our cards to try to find a suitable helper for each old person. Great care is taken in selection, and the value of the scheme is enhanced if the old person and the helper live near each other

FINANCIAL MATTERS

We pay our helpers 1*s* 9*d* per hour plus bus fare The old people pay 2*s* 6*d* per hour and some of them receive the total cost from the National Assistance Board Many battles are waged on this point. It frequently occurs that, when the old person receives the extra money from the National Assistance Board, he decides to do without the help or to have 2 hours instead of 4, etc The skill and tenacity of old people on matters of finance are constant tests of our own intelligence

In some cases sons or daughters pay the cost—one old lady pays the helper 2*s* for her 4 hours' help, and the son and the daughter in law pay the balance direct to the office The old lady does not know this, since she thinks 6*d* an hour good money A number of old people pay the full amount themselves and are very grateful for the service

We receive a grant from the Dispensary Committee (a local charity), which covers insurance stamps, additional hours worked in emergencies, cases where payment is not recovered, and bonus of 10*s* where a particularly dirty job is undertaken

TRAINING

Training is done on an individual basis There is such variety among our helpers that I would hesitate to try group talks, nor do I think that such talks would be appealing

Each helper calls at the office at least once every week to pay in the money she has collected from her old people and to collect her own wages On these occasions we discuss the old people she visits If additional services, such as chiropody treatment or mobile meals seem to be desirable, we ask the helper to discuss the matter with the old people. Other problems (like the reluctance of an old man to change his shirt or to get up in cold weather, or the old lady who spends 9*s* a week on her two cats out of her National Assistance and then cannot pay the helper) are also talked over By regularly discussing the problems, the helpers develop great skill in dealing with old people Their techniques vary from threats to cease visiting to constant praise and flattery, and at the bottom of it all is a genuine affection

5

An Important Swedish Epidemiological Study

In 1954 Larsson and Sjögren published an exceedingly thorough and valuable study of the mental health of a large Swedish rural population[2] Not only is their investigation important for the factual information it yields about indigenous mental health conditions but it is, in addition, an important methodological contribution

The region studied consists of thirteen parishes located on two large islands and a number of adjacent smaller ones off the west coast of Sweden These islands are situated near the mainland and for the purposes of the study are referred to as "AB bo" In spite of its relative isolation this population is considered as representative of the Swedish rural population as a whole The very fact of isolation makes the area ideal for long term study because it has been relatively free of large scale migrations During the present century it has tended to diminish some in population through emigration, but, in spite of this, it has remained reasonably stable and relatively uncontaminated by the influx of any appreciable numbers from parishes outside the region

POPULATION STUDY

The investigators carefully searched the parish records for all instances of mental disorder or deficiency (see discussion of this registration in chap vii above) for the period January 1, 1900, to December 31, 1944, and supplemented this effort by combing the records of mental hospitals and institutions normally serving the inhabitants of this area for additional cases. Finally, a thorough field investigation of the region was made to insure that the highest possible percentages of cases of mental disorder could be discovered and correctly diagnosed In this way 1312 cases of psychosis, severe psychopathy, low grade oligophrenia (marked mental deficiency), and suicide were identified for the 45 year period covered by the study Among these were 763 psychotics, 65 psychopaths, and 320 oligophrenics

Of methodological interest is the fact that only 83 6 per cent of the instances of psychosis and psychopathy were discovered through hospital records While this is the great majority of cases, a not inconsiderable proportion of the study population would have been missed were these records the only source of information That Sweden's unique parish records were of substantial value is indicated by the fact that 13 6 per cent of the cases were uncovered from this source alone, while an additional 2 per cent came from the records of the welfare organization These percentages refer to the identification of the 745 psychotic and psychopathic probands or index cases upon which the genetic aspects of the study were based Field investigation and interviews aided substantially in locating secondary cases related to the probands but

[1] This account was prepared by Robert W Kleemeier, professor of psychology, Washington University, St Louis, Mo

[2] T Larsson and T Sjogren *A Methodological, Psychiatric, and Statistical Study of a Large Swedish Rural Population* ("Acta psychiatrica et neurologica Scandinavica," Suppl 89 [Copenhagen, 1954])

who did not appear in any of the records mentioned above

NON HOSPITALIZATION

This careful work illustrates well the inadequacy of estimates of prevalence of mental illness based solely upon hospital records While study of hospitalization rates are valuable and necessary in and of themselves, generalizations concerning the mental health of regional and national groups derived entirely from this source may be misleading The reason for this cautious approach is made apparent in *Table 1* Here we see that, of 1148 cases of mental disorder occurring in "AB bo" during the 45 year investigation period, less than two-thirds were hospitalized or placed in an institution. Almost one fifth of the psychotics did not enter a mental hospital, and only one-quarter of the mentally deficient were admitted to an institution for their disorder

Of the 148 psychotics who were not hospitalized 107, or 72 per cent were registered as "undiagnosed psychosis" This is not surprising, since such persons are less likely to be observed by a competent diagnostician than are hospitalized patients

ou u in the hospitalized cases

AGE AT ONSET OF PSYCHOSIS AND AGE AT HOSPITALIZATION

Estimates of the amount of non hospitalization' when based upon data gathered within a sharply defined period of time will contain some error, because cases developing *near the* end of the period and hospitalized *after the* termination date are wrongly classified In other words the late occurring case is placed in the 'non hospitalized' category even though hospitalization may in fact occur after the end of the study period

This technical point brings up the problem of the relationship between time of onset of psychosis and time of hospitalization, which has important bearing upon the estimation of prevalence of psychosis by age Heretofore (in chap vii above) we have had to rely completely on age at hospitalization or upon age frequency distributions of hospital populations in order to form a picture of the mental health of the aged For Sweden, however, the thorough *methods of* the present study give us a clue concerning the age of onset of mental disorder of an entire regional population

TABLE 1*

"NON HOSPITALIZATION" OF THE MENTALLY ILL AND MENTALLY DEFICIENT IN A SWEDISH RURAL AREA ('AB BO'), 1900-1944

Diagnosis	Cases Not Hospitalized		Total No of Cases
	No	Per Cent	
Men	239	41 0	583
Psychosis	69	19 9	346
Psychopathy	23	60 5	38
Oligophrenia	147	73 9	199
Women	187	33 1	565
Psychosis	79	18 9	417
Psychopathy	14	51 3	27
Oligophrenia	94	77 7	121
Both sexes	426	37 1	1148
Psychosis	148	19 4	763
Psychopathy	37	57 0	65
Oligophrenia	241	75 0	320

* Source T Larsson and T Sjögren, *A Methodolog cal Psychiatr c and Stat l cal Study of a La ge Swedish Rural Populat on* ("Acta psychiatrica et neurologica Scandinavica Suppl 89 [Copenhagen, 1954]) p 101 Table 22

In 628 of the psychotic cases discovered in "AB bo the date of onset of the disease was definitely known The distribution of these by age is given in Table 2 *and is* represented graphically in Figure 1 along with the age distribution of first admissions to hospital of the hospitalized group The composition of the groups is obviously *not* identical but the great majority are represented in both distributions *Figure 1 shows clearly* the extent of the tendency for hospitalization *to occur* at a later age than the *onset of* the psychosis, note that the

5

An Important Swedish Epidemiological Study[1]

In 1954 Larsson and Sjögren published an exceedingly thorough and valuable study of the mental health of a large Swedish rural population[2] Not only is their investigation important for the factual information it yields about indigenous mental health conditions but it is, in addition, an important methodological contribution

The region studied consists of thirteen parishes located on two large islands and a number of adjacent smaller ones off the west coast of Sweden These islands are situated near the mainland and for the purposes of the study are referred to as "AB bo" In spite of its relative isolation this population is considered as representative of the Swedish rural population as a whole The very fact of isolation makes the area ideal for long term study because it has been relatively free of large-scale migrations. During the present century it has tended to diminish some in population through emigration, but, in spite of this it has remained reasonably stable and relatively uncontaminated by the influx of any appreciable numbers from parishes outside the region

POPULATION STUDY

The investigators carefully searched the parish records for all instances of mental disorder or deficiency (see discussion of this registration in chap vii above) for the period January 1, 1900, to December 31, 1944, and supplemented this effort by combing the records of mental hospitals and institutions normally serving the inhabitants of this area for additional cases. Finally a thorough field investigation of the region was made to insure that the highest possible percentages of cases of mental disorder could be discovered and correctly diagnosed In this way 1312 cases of psychosis, severe psychopathy, low grade oligophrenia (marked mental deficiency), and suicide were identified for the 45 year period covered by the study Among these were 763 psychotics, 65 psychopaths, and 320 oligophrenics.

Of methodological interest is the fact that only 83 6 per cent of the instances of psychosis and psychopathy were discovered through hospital records. While this is the great majority of cases a not inconsiderable proportion of the study population would have been missed were these records the only source of information That Sweden's unique parish records were of substantial value is indicated by the fact that 13 6 per cent of the cases were uncovered from this source alone, while an additional 2 per cent came from the records of the welfare organization These percentages refer to the identification of the 745 psychotic and psychopathic probands or index cases upon which the genetic aspects of the study were based Field investigation and interviews aided substantially in locating secondary cases related to the probands but

[1] *This account was prepared by Robert W Kleemeier professor of psychology, Washington University, St Louis, Mo*

[2] T Larsson and T Sjogren *A Methodological, Psychiatric and Statistical Study of a Large Swedish Rural Population* ("Acta psychiatrica et neurologica Scandinavica," Suppl 89 [Copenhagen, 1954])

MORBIDITY RISK

The morbidity risk for a particular disease at any age may be defined as the percentage of the total population at this age affected by the disease. Thus the morbidity risk for disease *x* at age 30 in Sweden would be the percentage of all the 30 year-olds in the entire population of Sweden who had this particular disease. The *aggregate* morbidity risk for this disease would be the sum total of the morbidity risks of the disease for all ages. Note particularly that aggregate morbidity risk is *not* the percentage of people in a population affected by a disease but rather is the sum of the percentages of persons affected at each age.

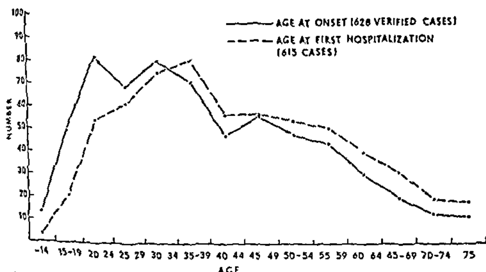


FIG 1.—Distribution of psychotic cases in a rural Swedish area by age at onset of psychosis and at first hospitalization. (After T Larsson and T Sjögren, *A Methodological, Psychiatric, and Statistical Study of a Large Swedish Rural Population* ["Acta psychiatrica et neurologica scandinavica" Suppl 89 (Copenhagen, 1954)] pp 125-26 160, Tables 30 and 31.)

TABLE 3*

LIFE EXPECTANCY FOR PSYCHOSIS AND OLIGOPHRENIA, SWEDEN

Main Diagnosis	Remaining Mean Expectation of Life as a Percentage of That for the General Population 1900-1944			
	All Affected and Previously Affected Cases		All Hospitalized and Previously Hospitalized Cases	
	Male	Female	Male	Female
Schizophrenia	72	63	68	54
Manic-depressive psychosis	95	91	88	75
Senile psychosis	50	60	35	45
Presenile psychosis	60	67	52	63
Psychosis all forms	71	67	66	57
Low grade oligophrenia	70	70	60	60

* Source T Larsson and T Sjögren *A Methodological Psychiatric and Statistical Study of a Large Swedish Rural Population* ("Acta psychiatrica et neurologica Scandinavica" Suppl 89 [Copenhagen 1954]) p 179 Table 44

modal age of onset is between 20 and 24 years, while the mode for hospitalization falls in the age interval 35–39

The records reveal that in only about one third (37 per cent) of the cases did hospitalization take place during the same calendar year as the onset of the disease In 3 years about two-thirds of the hospitalized cases were admitted, and in 6 per cent of the cases the interval was 20 years or more The delay in hospitalization for the senile mental disorders tends to be somewhat less than the average because of the high age of onset and the rapid progress of the disease, that is, unless hospitalization is fairly early, the patient may die before being admitted

TABLE 2*

DISTRIBUTION OF PSYCHOTIC CASES IN A RURAL SWEDISH AREA BY AGE AT ONSET OF PSYCHOSIS AND AT FIRST HOSPITALIZATION†

Age	Onset of Psychosis		First Hospitalization
	All Cases‡	Verified Cases Only§	
Under 14	13	13	3
15 19	54	49	21
20–24	102	82	54
25–29	71	68	61
30–34	88	79	74
35–39	78	70	80
40–44	63	47	56
45–49	68	55	56
50–54	66	47	53
55–59	58	43	50
60–64	43	30	39
65–69	27	20	31
70–74	19	13	19
75 and over	13	12	18
Total	763	628	615

† Does not include psychopathy

‡ Includes all cases including those in which age of onset was estimated

§ Includes only those cases in which age at onset was verified

The mean age at onset for the various diagnostic categories of this population were as follows

	Age at Onset (Years)
Schizophrenia	
Male	28 0
Female	31 8
Hebephrenia	23
Catatonic schizophrenia	35
Paranoid schizophrenia	46
Manic-depressive psychosis	
Male	42 4
Female	40 4
Senile psychosis	70 5
Presenile psychosis	54 4

DIAGNOSIS

Of the 763 cases of psychosis identified over the 45 year period of the "AB bo" study, 34 2 per cent were diagnosed as schizophrenia and 18 1 per cent as manic depressive psychosis Senile and presenile psychosis accounted for 14 9 per cent of the total Other specified diagnoses were given in 18 1 per cent of the cases, and the remaining 14 7 per cent could not be diagnosed These data emphasize the tremendous burden imposed by the single cluster of diseases known as schizophrenia In 1951 it was estimated that, of all Swedish hospital beds for both somatic and mental illnesses, some 22 per cent were occupied by schizophrenic patients

EXCESS MORTALITY

Various mental diseases affect future life-expectancy to markedly different extents but always unfavorably In Table 3 the "AB bo data provide a basis for the estimates of these influences in Sweden undoubtedly, these figures have considerably wider application Here the relatively poor prognosis for senile psychosis is emphasized Hospitalized or previously hospitalized male patients with this disease can expect on the average only 35 per cent of the number of years of life remaining to their age group In general, psychosis appears to have a more severe effect for women than for men, and hospitalization as a consequence of psychosis seems to be an additional indication of further reduction in life expectancy

MORBIDITY RISK

The morbidity risk for a particular disease at any age may be defined as the percentage of the total population at this age affected by the disease. Thus the morbidity risk for disease x at age 30 in Sweden would be the percentage of all the 30-year-olds in the entire population of Sweden who had this particular disease. The *aggregate* morbidity risk for this disease would be the sum total of the morbidity risks of the disease for all ages. Note particularly that aggregate morbidity risk is *not* the percentage of people in a population affected by a disease but rather is the sum of the percentages of persons affected at each age.

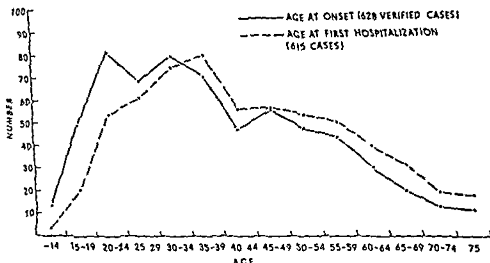


FIG. 1.—Distribution of psychotic cases in a rural Swedish area by age at onset of psychosis and at first hospitalization. (After T. Larsson and T. Sjögren, *A Methodological, Psychiatric, and Statistical Study of a Large Swedish Rural Population* ["Acta psychiatrica et neurologica scandinavica," Suppl. 89 (Copenhagen, 1954)], pp. 125–26, 160, Tables 30 and 31.)

TABLE 3*

LIFE EXPECTANCY FOR PSYCHOSIS AND OLIGOPHRENIA, SWEDEN

MAIN DIAGNOSIS	REMAINING MEAN EXPECTATION OF LIFE AS A PERCENTAGE OF THAT FOR THE GENERAL POPULATION, 1900–1944			
	All Affected and Previously Affected Cases		All Hospitalized and Previously Hospitalized Cases	
	Male	Female	Male	Female
Schizophrenia	72	63	68	54
Manic-depressive psychosis	95	91	88	75
Senile psychosis	50	60	35	45
Presenile psychosis	60	67	52	63
Psychosis, all forms	71	67	66	57
Low-grade oligophrenia	70	70	60	60

* Source: T. Larsson and T. Sjögren, *A Methodological, Psychiatric, and Statistical Study of a Large Swedish Rural Population* ("Acta psychiatrica et neurologica Scandinavica," Suppl. 89 [Copenhagen, 1954]), p. 179, Table 44.

In the "AB bo" study aggregate morbidity risks were calculated for various mental disorders For the purposes of the study the calculations were based only upon data up to and including age 80, and various corrections were applied to minimize the effects of incompleteness of data and lateness in registration The results of these calculations are as follows

	Per Cent
Schizophrenia	1 6
Manic depressive psychosis	
Male	0 9
Female	1 2
Presenile psychosis	
Male	0 7
Female	1 0
Senile psychosis	
Male	0 6
Female	0 8

Since the aggregate morbidity risks are not based upon ages over 80, the estimates for senile psychosis are necessarily less stable than are the others The aggregate morbidity risks for all forms of psychosis are estimated to be 4 7 per cent for men and 5 7 per cent for women Larsson and Sjogren believe that because of the difficulty in securing absolutely complete data, these estimates are if anything too low They feel that the risk is more likely to be 5 per cent for males and 6 per cent for women than any lesser figure

ASSESSMENT OF PREVALENCE OF PSYCHOSES IN SWEDEN

With the knowledge gained in the "AB bo" study about morbidity risk and excess mortality in relation to psychoses, it was possible to make estimates about the prevalence of mental disease in Sweden Since population projections were available, future predictions as well as estimates for the past could be made These figures for the years 1945 and 1965 are given in Table 4

This table reveals the almost staggering problem mental illness presents, and there is no reason to believe that it is unique to Sweden We see that the estimate of the number of persons affected or previously affected by psychosis at the end of 1945 was 90 000 and that by 1965 this number is expected to increase to 108 000 When one takes into account the fact that this is for a population of between 7 and 8 million people, one can imagine the extent of the problem in the United States with a population well over twenty times that of Sweden

TABLE 4*

ESTIMATED NUMBER OF PERSONS WITH PSYCHOSIS OR PREVIOUSLY AFFECTED WITH PSYCHOSIS IN SWEDEN 1945 AND 1965
(In Thousands)

Main Diagnosis	Calculated No of Affected and Previously Affected Persons in Total Swedish Population at End of Year					
	1945			1965		
	Men	Women	Both Sexes	Men	Women	Both Sexes
Schizophrenia	21	18	39	24	20	44
Manic depressive psychosis	8	14	22	10	17	27
Senile and presenile psychosis	3	6	9	5	8	13
Other psychoses	10	10	20	12	12	24
All psychoses	42	48	90	51	57	108

* *Source* T Larsson and T Sjögren *A Methodological Psychiatric and Statistical Study of a Large Swedish Rural Population* (Acta psychiatrica et neurologica Scandinavica, Suppl 89 [Copenhagen 1954]) p 210

MENTAL HEALTH NEEDS IN SWEDEN

Larsson and Sjögren are quick to point out the implications of their findings for Sweden They admit that their calculations are in many respects uncertain and that their predictions may be influenced by as yet unknown trends and factors (e g increased inland migration urbanization industrialization etc.) Nevertheless they believe that their findings clearly show the extensive problems in this field that will confront the public health authorities and the great demands that must be made for a rapid extension of accommodation for the mentally diseased and the mentally deficient."[3]

No specific mention is made of the increasing pressure exerted by the mounting numbers of the aged in this aggregate of the mentally ill but Hagnell documents well the increasing importance of this aspect of the problem [4]

[3] *Ibid.*, p 211

[4] O Hagnell "Psykoser hos aldre manniskor, ett vaxande psykiatriskt problem" (Psychosis in the Aged an Increasing Psychiatric Problem") *Nord med*, 51 (1954), 737–42

6

A District Mental Health Service[1]

Now being carried out in a town on the Sussex coast is an experimental attempt at demonstrating a superior way of meeting the problem of hospital overcrowding by use of an intensive outpatient service which has special implications for the aged mentally ill Carse, Panton, and Watt, the authors of the first report on this study, point out that for more than a century therapeutic emphasis has been upon treatment of the mental patient in hospital Until 1930 in Great Britain there were few outpatient clinics and little encouragement existed for early treatment "Even today [1958]," they say, "for the great majority of mentally ill patients, treatment still means admission to mental hospital "[2]

Recognizing the full importance of the problem of overcrowding, they dismiss the possibility of its solution by the building of new hospitals not only because of tremendous construction and operating costs but also because the difficulties in staffing new institutions would be too great Their solution calls for great expansion of outpatient treatment facilities, and the apparently successful experiment at Worthing supports the validity of their claims This experiment, designed as a 2 year pilot study, began on January 1, 1957 The following report is based upon the experience of the first 10 months

Worthing is a Sussex coastal resort town of about 70,000 population, located some 60 miles south of London The experimental catchment district extended over a semicircular area radiating between 8 and 9 miles from the clinic center and including in its boundaries approximately 160,000 people This district is served by Graylingwell Hospital, and the Worthing unit was set up as an experimental outpatient and domiciliary treatment facility of that hospital Worthing is located 22 miles from the parent institution—a deliberately chosen factor in the experimental situation in order to test the practicability of providing "psychiatric treatment for large numbers of patients without the immediate availability of the resources of a modern mental hospital "

All patients of the unit were referred by the family physician excepting a few patients who were directed by the courts to attend All admissions to Graylingwell from the Worthing catchment area were screened by the unit The population of this region is varied and contains one of the highest percentages of aged people in England and Wales

STAFF

The twenty bed unit served as an active treatment center and day hospital There were no resident patients On the staff were three psychiatrists (two full time and one part time), a trained psychiatric nurse, two staff nurses, two ward orderlies, an occupational therapist, a medical secretary, and a clerical helper, plus some additional per

[1] This account was prepared by Robert W Kleemeier, professor of psychology, Washington University, St Louis, Mo

[2] J [illegible] and A Watt 'A District M[illegible] ng Experime[illegible] —41

sonnel from Graylingwell. Social work was done by a psychiatric social worker and a hospital almoner.

PATIENTS

During the first 10 months, 1192 patients (376 male and 816 female) were seen; of these 318 were 65 years or older. The psychiatric outpatient clinic of the general hospital was included in the service, thereby strengthening the relationship with local general practitioners—a relationship necessary for the success of the scheme.

TREATMENT

Over a thousand domiciliary visits were made by the unit's psychiatrists to 432 patients during the period of report. The social workers assisted here to sort out the problems presented by these patients. Each patient received a thorough physical examination. Psychiatric treatment included extensive use of electroconvulsant therapy and some modified insulin therapy, while, for many, psychotherapy was the main treatment. The latter was given individually or in a weekly group psychotherapy session. No patient fees were charged.

EFFECT ON HOSPITAL ADMISSION

In Table 1 the effect of this experimental effort at Worthing on admissions to Graylingwell and Summersdale hospitals is shown. Summersdale is a short stay subsidiary hospital for Graylingwell. During 1957 the admissions from the catchment area served by the Worthing unit decreased by 324, a drop of 59 per cent, while admissions from a control area, similar in size and composition of population, increased by 4 per cent.

As might be expected, the Worthing service appears to have a greater effect upon admissions to the short stay unit at Summersdale than to the main hospital, Graylingwell. This was anticipated because it had been thought that many of the recoverable patients being sent to Summersdale could indeed forego hospitalization, provided other help were available. What was surprising to the investigators, however, was the 40 per cent drop in admissions to Graylingwell, because cases admitted there were usually intractable. As is indicated in Table 2, a greater percentage reduction was experienced for women than for men.

The reduction in admissions from the Worthing area was somewhat less for aged patients than for the total for all age groups, although here, too, it was substantial, as may be seen in Table 3. With advanced age, beyond 75, the reduction seems least, but, nevertheless, even for this age group, the 1957 admissions were less than two-thirds of those in the corresponding 1956 period. Elderly patients (those between ages 65 and 75) are quite reluctant to enter the mental hospital, and for these the Worthing service was particularly well

TABLE 1*

ADMISSIONS TO GRAYLINGWELL HOSPITAL AND SUMMERSDALE HOSPITAL

Admissions	Year		Difference
	1956	1957	
From catchment area served by Worthing service	548	224	−324 (−59%)
From catchment area *not* served by Worthing service	603	626	+ 23 (+4%)
Total	1151	850	−301 (−26%)

*Source: J. Carse, N. E. Panton and A. Watt, "A District Mental Health Service: The Worthing Experiment," *Lancet*, January 4, 1958, pp. 39–41, Table 1.

suited The authors take a cautious attitude, however, concerning the results with older patients, for, although the reduction in admissions was maintained for the full 10 months covered in the report, marked fluctuations in the admission of senile patients may be expected

OBSERVATIONS

The investigators believe that hospitalization is unnecessary for a large proportion of patients now being admitted to mental hospitals and that these persons may be treated successfully as outpatients While the mental hospital is not considered as being outmoded, it is believed to have a more limited function than is now assigned to it It is seen "as a hospital for selected patients mostly with good *prognosis, but* needing special treatment and conditions which cannot be provided by an outpatient service"

Good public relations are viewed as a basic requirement for the successful outpatient service, in Worthing the public had been prepared through various educational and publicity media for a number of years before the establishment of the service This groundwork had also in large measure dissipated the fear of Graylingwell, for in 1956, 85 per cent of new admissions to this hospital were either non statutory or voluntary a figure above the national average

*TABLE 2**

ANALYSIS OF ADMISSIONS FROM WORTHING AREA

Year	Graylingwell Hospital			Summersdale Hospital			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1956	108	152	260	69	219	288	177	371	548
1957	69	88	157	22	45	67	91	133	224
Reduction	39	64	103	47	174	221	86	238	324
Per cent reduction	36	42	40	68	79	77	49	64	59

* Source J Carse N E Panton and A Watt A District Mental Health Service The Worthing Experiment *Lancet* January 4 1958 pp 39–41 Table II

TABLE 3*

ADMISSIONS AMONG ELDERLY PATIENTS

Age	Year		Difference
	1956	1957	
65–69	57	20	−37 } −55 (−51 4%)
70–74	50	32	−18 }
75–79	31	18	−13 } −24 (−38 7%)
80 and over	31	20	−11 }
Total	169	90	−79 (−46 9%)

* Source J Carse N E Panton and A Watt A District Mental Health Service The Worthing Experiment" *Lancet* January 4 1958 pp 39–41 Table III

IMPLICATIONS

The implications of the Worthing experiment are not being disregarded by either the politicians or the public British attitudes toward mental health are in flux and traditional methods in dealing with the problem of mental illness are subject to criticism and widespread change is inevitable Dr Donald McI Johnson Member of Parliament for Carlisle says that the improper admission of patients is one of the greatest problems confronting mental hospitals today [5] Though always legally

[5] Donald McI Johnson "New Deal Lies Ahead for Mentally Sick *Bristol Evening Post* February 5 1958 p 2

correct he charges that in too many cases the basis for hospitalization is medically and psychiatrically unsound He supports his argument by referring to the Amsterdam system and the Worthing experiment. General adoption of similar services throughout Britain he believes would save upward of $28 million (£10 million) annually and would produce vastly superior therapeutic results than are at present obtained Unquestionably, much can be learned by observing the steps taken in Great Britain during this period of critical self examination and change

7

A Case Study of Family Relations[1]

The following case is typical of the well-to do bourgeoisie, professional, Catholic family in which familial ties are very strong The same type of relations would be found in the upper middle class They are, however, more extensive in the upper-upper-class family The frequency and solidarity of these relations are conditioned by residential proximity But in France, where geographical mobility is not nearly so extensive as in the United States, neighborhood proximity is less rare Children intermarry and live in the same city as the parents With important economic aid of the grandparents, vacations are very often taken together by three generations For example, the grandparents own or rent a villa on the seashore or in the mountains

Residence of the family is in a French city of 100,000 inhabitants 150 miles from Paris It has machine and textile industry and is quite prosperous

THE GRANDFATHER

The grandfather is 61 years of age

Occupation He is a non-specialist physician in general medical practice, with the responsibility for hospital service, to which he devotes his mornings He receives patients at his home 5 days a week from 2 00 to 5 00 P M and afterward makes home visits to 8 00 P M

Economic level His professional income is about $10,000 a year, to which is added a certain income (about $4000) derived from his investments These are constituted in large part of the estate which he inherited from his father

Of this $14,000, he expends about $6000 and invests the remainder in stocks

Social status He belongs to the first rank of the "professionals" of his city, who confer on him numerous honorific duties and consider him as the moral leader of doctors not only of the city but of the country

His type of life and the esteem which he enjoys are characteristic of the upper middle class The upper upper class in the city is constituted of about fifty industrial families who have very considerable income and form a quite closed circle

Hobbies He buys books (especially literary ones) follows daily the transactions of the stock exchange, listens to the radio a little, sees a movie once a year, purchases some "long playing" records, participates in several learned societies (medical and literary), and travels to the French provinces one month each year but never in foreign countries

THE GRANDMOTHER

The grandmother is 54 years of age Her social origin is in a Parisian social milieu of an older and more refined bourgeoisie than her husband's She is interested in fashions, in beautiful furniture, in the latest novel, and in the current plays in Parisian theaters She has little use for social life She spends her days at home, where she manages her household (having one servant) She goes to Paris once every week,

[1] This account was prepared by Dr Jean René Tréanton, Centre National de la Recherche Scientifique, Paris

where she sees her mother (82 years old) her sister and the members of the fam ly who live in Paris

RELATIONS WITH CHILDREN

There are four children a daughter Madeleine 28 (married), a son Jacques 26 (married) a daughter Helene 24 (mar ried) and a son Henri 21 (unmarried)

THE CHILDREN

The two daughters attended high school before their marriage but do not have an occupation apart from marriage The son Jacques pursues his highly specialized med cal studies the son Henri the science of agriculture During their childhood they spent one month each year during the summer at the seashore The grandparents have offered them several trips outside France Each of them equally had the opportunity of spend ng 15 days nearly every year in the mountains during the winter in order to ski

The youngest child Henri is still entirely supported by his parents who take care of his expenses at the technical college They offer him a trip during the summer vacation and 15 days in the mountains in winter They give him about $30 a month for his personal expenses For the last 3 years he has made h s internship on a large farm, where he is learning practical agri culture He has saved about $100 His great ambition is to own an automob le provided his father helps him out He hopes to get it now that he has completed his 2 years of military service which exp red at the beginning of 1960

The three married children are no longer supported by their parents There is an exchange of presents at Christmas and cer tain holidays and anniversar es The pres ents given by the parents are generally a l ttle more valuable than those which they receive from the children.

There is one exception to this general p cture The son Jacques who pursues his med cal stud es and who has been recently married is lodged free by his parents in a small apartment which they own in Paris

RELATIONS WITH THE GRANDCHILDREN

Only the older daughter, Madeleine has children one boy of 8 years Remy a daughter of 5 years Martine, and a son of 2 years Gerard They live a short dis tance from the grandparents in the same city two blocks away Also the relations between the grandparents and the grand children are very frequent Some of the examples are

1 Mutual visits are exchanged at least once every day Generally the grandchil dren come to see the grandparents at the close of the elementary school Very often one of the two older children remains to take lunch with the grandparents.

2 When one of the children is ill the two others live with the grandparents to avoid contagion

3 The grandchildren are entirely taken in charge by the grandparents if the par ents go on a trip or out for the evening

4 Almost every Sunday there is the family meal which brings the three gen erations together at the home of the grand parents After lunch the grandparents gen erally take the grandchildren and their mother out for a walk The father takes advantage of this to play golf or to remain at home to read or work.

5 During the summer vacation the grandparents take the grandchildren several times to the seashore or the mountains, thus giving their children their freedom At other times they rent a villa in com mon and the three generations spend the vacation together

The ties of affection between the grand parents and the grandchildren are very strong The grandparents play an essential role in the socialization of the grandchil dren (e g reading out loud or explaining the comics or telling them stories) The grandchildren have the tendency to con sider the house of their grandparents as their real dwell ng and their preferred home

THE GREAT GRANDMOTHER

The great grandmother (82 years), mother of the grandmother, lives in Paris but visits her daughter every 2 months She remains almost 3 weeks (so much that in the course of a year she lives with her daughter about 15–18 weeks) She spends with them equally the greater part of the summer vacation During the remainder of the year her daughter will visit her at least once a week and often takes one or two of the great grandchildren with her The great grandmother gives them numerous presents The ties of affection between them are very strong, although the great grandchildren have a tendency to consider her as "terribly old"

OTHER RELATIVES

The great grandmother has two other children, a daughter, Anne (57 years), married, without children, and a son, Pierre (47 years), who has six children between 6 and 18 years of age

Relations with Anne Anne lives in Paris, some 500 feet from the great grandmother Anne would like to move to the outskirts of the city, but she has decided not to do so as long as her mother is alive They meet every day, Anne having her mother over for dinner or for lunch at least once a week As Anne has a car, she is often ordered by her mother to bring her to the center of the city to do some shopping, which is the favorite diversion of this old lady Anne generally tries to escape it, and this is one of the subjects of complaint by her mother

Relations with Pierre The great grandmother spends practically all Sundays at Pierre's house when she is in Paris The daughter in law complains a little that the responsibility of carrying on the conversation with the great grandmother is entirely hers and is not shared by Pierre, who is accustomed to escape The grandchildren slip away too The great grandmother greatly enjoys giving them lessons in education or in speaking of their "beaus" with the two elder granddaughters

Another very important person in the great grandmother's life is her brother (76 years) They meet at least twice during the week (one being a lunch at his home) A wealthy retired executive, he helps her financially with some small gifts His health is not very good, and, certainly, his death would deeply affect her

The great grandmother was completely ruined financially in 1930 by a dishonest broker Since that time, she has lived on a small pension given her by her three children

Except for her health (bad legs and high arterial tension), she is well adjusted very talkative, always busy with problems of hats and dresses, not at all religious but very fearful of leaving this good world Her daughters consider her "childish", they joke about her taste for reading love stories She reads a great deal or listens to the radio when alone, but she is rarely alone

8

The Three-Generation Rural Family in Italy[1]

In the twelve rural villages in Abruzzia the three-generation family is the rule The old people never live alone in the house Usually the oldest son his wife and his children live with them Sometimes the old parents prefer to live with a daughter and her husband

The living together of the generations is economical The old women in one of the twelve villages make the ancient *ricamo* and *merletto* which is very fine embroidery work. In wintertime this work of the grand mother is almost the only economic resource of the family This fact is very important since it gives the grandmother a significant economic role in the family

When the young couple is working in the fields the grandmother keeps house The grandparents take care of the children They are more strict with them than the parents Obedience and reverence for the grandparents are general One of their roles is that of educators of the grandchildren The grandmother is accustomed to help the grandchildren with their homework

It is natural to have the old people at home They do not constitute a problem Sometimes we find only old people and their grandchildren in the household The mother and father will be elsewhere in Italy or in other countries

At times the old father in law lives alone because it is hard for him to keep in accord with the daughter in law In this case the daughters in law take turns in caring for him Such a situation often is a subject for discussion in the community The people are divided between those who say that it is wrong and those who say that it is right.

In case of sickness the old people are well attended The community is likely to criticize a daughter in law who does not take good care of her father in law and mother in law

When old people are sick, the relatives do not call the doctor, because they are convinced that the doctor can do nothing for old people The old people are always kept in the home of one of the children—sometimes one of the daughters if they feel that they are better looked after by daughters than by daughters in law

The old women are counselors in matters of maternity cooking medicine, and clothes People are often afraid of the power of their chatter For many hours of the day they sit in front of the houses on the village square commenting on and controlling every event

The old people are very influential even if they are poor and propertyless People go to them to find a mediator in case of fights Old people are deeply respected

There are fifteen residents in the home for old people in this area They are all without families There is no one living there who has family or relatives to care for him In nearly every case this situation is a result of emigration of the adult children.

One village woman took an old blind woman into her home when she became too

[1] This account was prepared by Miss Angela Zuccino dean School of Social Work, Rome, Italy

frail to work or to care for herself The latter had no one left of her family She has been there now for over a year She is bedbound The daughters in the family keep her bed clean They gave her their own room when she came It would never occur to them to resent in any way her being taken into their home They treat her with great respect

Today changes are taking place in the villages Old people are much more connected with the church than are their children Young people go to church more indifferently The young generation does not buy books The books in the home belong to the old generation Social security is changing the role of old people and their relationship with their children

9

Relations with Their Children of Parents in an Old People's Home[1]

Miss Margrit Kessi, of the School of Social Work in Zurich, has made a study of the relations with their children of parents living in an old people's home in Switzerland Interviews revealed that with nearly all of them some kind of relation was maintained, especially through mutual visits Less often were letters exchanged, common trips undertaken, or any kind of services provided Most parents received presents now and then from their children, while it was seldom possible for them to give their children presents, since as a rule they had only limited pocket money

Family relationships were differently assessed by those questioned Barely a half described them as "good" The remainder characterized them as "average" or "bad" The answers of the old and the young did not always agree It appeared that external factors (such as social class dwelling accommodations the distance from the residence to the old people's home, or the state of health on both sides) were not primary for good, indifferent and bad relations The attitudes to one another of parents, children and grandchildren counted far more

In particular, the attitudes of the parents to their entrance into the old people's home influence the mutual relations The old people report the relation to their children as good only if they have reconciled themselves to living in the old people's home Others are embittered not to be able to live with a son or daughter Even if this were attempted, it might lead to unfortunate results on both sides. It strikes many parents as unnatural not to live with the child For this most of them blame the in-law child. The old generation grew up in the period when the three generation family was the norm. The loss of the functions of the family through industrialization and individualization resulted in the family's becoming smaller In the small family there was seldom any room for relatives of the married pair Or, if so, living together led to constant irritations Numerous old men could not keep step with this change and therefore suffer under the present conditions, which they can recognize only as a personal fate and not as social change

Where the children do not report the relation as good, the cause is overwhelmingly to be discovered that in childhood or youth they experienced too little parental love This clearly was expressed in several cases Nevertheless, they worry about their progenitors because of feelings of their duty Yet very few of these would take the father or mother to live with them

It is questionable how one can help the old people who are unhappy in the old people's home because they feel rejected by their children A realistic influencing of their attitudes can scarcely be possible Yet a regular hearing of their grief by a volunteer helper can somewhat mitigate the bitterness of the feeling

[1] This account has been translated from *Pro senectute* 36 (June 1958), 52–54

10

Duty of Children To Support Parents[1]

FRANCE

According to Article 205 of the Civil Code of 1804, as amended by the law of March 9, 1891, "the children owe support to their father and mother as well as to other ascendants who are in need of support"

Under Section 206 of the Code as amended by the law of August 9, 1919, a duty of support is also incumbent upon a son in law and a daughter in law as against a father in law or a mother in law

WEST GERMANY

Under Sections 1601 *et seq* of the Civil Code of 1896, mutual duties of support exist between relatives in the ascending and descending line A person is therefore under a duty to furnish support to his father, his mother, his grandfather, his grandmother, and also to more remote ascendants if they are in need of such support

GREAT BRITAIN

Under the common law of England children are under no duty to provide support for their parents A limited duty was established, however, under the poor laws, the latest version of which was contained in the Poor Law Act, 1930 (c 17), Section 14 This law was repealed by the National Assistance Act, 1948, Sixth Schedule, paragraph 19(1) By Section 42 of the National Assistance Act, 1948, duties of support are incumbent only upon a husband as against his wife upon a wife as against her husband and upon both a man and a woman as against their children

ITALY

Under the Civil Code of 1942 Section 433, a person in need has the right to be supported by his legitimate or legitimated children or, if they are dead by his more remote descendants Under the same section mutual rights and duties of support also exist between son in law and daughter in law, on the one side and father in law and mother in law, on the other side

NETHERLANDS

Under the Civil Code of 1836 Article 376 'the children are under the duty to provide support to their parents and their ascendants in more remote degrees whenever such persons are in need of support' Article 377 provides a duty to support a person's father in law and mother in law [2]

SWEDEN

Under the Law on Family Relations (*Foraldrabalken*), Chapter 7 Article 3, children are under a duty to provide support for their parents Under Chapter 3 of the Law on Public Assistance children are also under a duty to reimburse the assistance authorities for support furnished their parents

[1] This account was prepared by Dr Max Rheinstein Max Pam Professor of Law, University of Chicago

[2] [The duty of grandchildren to support grandparents is in process of being repealed.—EDITOR]

11

Clubs for Older People in an English Community[1]

Throughout the ages people of like tastes have met together to enjoy discussion of subjects of mutual interest and to exchange ideas, for example, in monasteries, medieval guilds, coffeehouses, political clubs and, in this century, townswomen's clubs, women's institutes, and the like Since the second World War, sponsored mainly by such voluntary bodies as old people's welfare committees, women's voluntary services, the British Red Cross Society, and many churches, there has been a rapid and nation wide development of clubs for the elderly Some of these clubs meet once weekly, some meet twice a week, and some are open every day Some meet in church halls, some in village halls, some in buildings specially designed to suit their special needs—with a kitchen, toilet facilities, a stage, and a hall—and some in a room in a private home The clubs usually meet from 2 00 to 4 30 P.M

MEMBERS

Members of these clubs join sometimes at 60 years of age, but more often at 65 There are many members well over 80 years of age and a few over 90 Most of the members come from the lower income group, with a few retired clerical workers To the best of my knowledge, no retired member of any of the professions is a member of any of our clubs Women members greatly outnumber the men in all clubs

LEADERS

The majority of club leaders are middle-aged married women whose children have left school and who find themselves with more leisure time A few of the helpers are younger married women with children in school A few retired single women are glad to interest themselves in this work

FINANCE

The clubs are self supporting Rents vary very much indeed Some clubs pay only *2s* a week, some, *7s 6d*, and one club, a guinea a week The club funds are raised by (1) a weekly subscription—mostly *4d*, or *3d*, including tea and a cake or bread and butter, (2) raffles, and (3) a "Bring and Buy Sale" once or twice a year, when members sew and knit, bake cakes, and make jam for the stalls at the sale (sometimes these sales are opened by some well known man or woman in the district)

Once a year each club receives a proportion (about £4) of a grant made to the Old People's Welfare Committee by the Borough Council from the Sunday Cinema Fund Some clubs receive a few annual donations or gifts in kind from individuals, local organizations, or tradesmen

[1] This is a description of the clubs for older people sponsored by the Old People's Welfare Committee of Chislehurst and Sidcup in Kent [illegible]

This account was prepared by Miss Bertha James, chairman of the Northw[illegible]

ACTIVITIES

All clubs arrange a number of outings during the year—to the sea, to churches, to cathedrals, to beauty spots, to historic houses, to factories, etc. All clubs have a Christmas party, a carol service, an Easter service, and a harvest festival Most clubs have a minister of religion who interests himself in their activities Many clubs have a charity in which they interest themselves —such as the blind or deprived children Some clubs have a concert party which goes round to hospitals and homes and entertains the patients Many clubs have film shows provided by British railways or coach companies or private individuals All clubs greatly enjoy entertaining visitors from overseas Most clubs play dominoes, checkers, darts, and whist and other card games One club issues, and sells for *2d*, a quarterly newssheet which gives items of interest about members and helpers and club activities generally This is particularly appreciated by club members when they are too frail to attend regular weekly meetings Some club members regularly visit sick members in hospitals Some clubs enjoy learning to make baskets The club leaders, week by week, listen to many stories of difficulties often connected with housing and health, and their practical help and advice in these matters are greatly appreciated Many clubs receive gifts of clothes dishes, and furniture These are usually sold, for very small sums to members for the benefit of the club Some clubs have members represented on a committee Many club members belong to two or even more clubs Three members from one club served as models for the girls' grammar school, and one modeled for the art school Of course the tea provided by the helpers is greatly enjoyed at every club meeting and teatime is the highlight of the afternoon

INTERCLUB EVENTS

A number of interclub events—bulb shows, luncheons, holiday trips, etc.—are held each year

Bulb show—The clubs plant daffodils hyacinths, crocuses, tulips, scillas, etc, every autumn and an interclub bulb competition is held each February Five challenge cups have been given for this event, and about thirty prizes are awarded annually in a number of different classes.

Luncheons—Six members of each club are invited to a luncheon in the Civil Defense Hall in Sidcup about four times a year The meal is prepared by helpers, and members pay *2s* each There is always a speaker, and slides are often shown This is one of the more recent activities and is rapidly growing in popularity

Holidays—Holiday schemes have been operating for some 9 years now Members are received in hotels in May and October at reduced prices, and transport by coach is provided Last year a most successful holiday was arranged at Pitlochy in the Highlands of Scotland At least one club helper accompanies each party

Adult education—Through the co-operation of the Kent Education Committee, for the last 3 years about forty club members (drawn from all clubs) have attended a course of four afternoon lectures in the warm and comfortable library of the Adult Education Centre at Lamorbey Park The subjects have been local history, national history historic homes and the appreciation of music A coach picks up members at various points in the district and drives them to and from Lamorbey The members pay *6d* each and the committee meets the balance of the cost Last year—and again this year—three prizes were awarded for the three best essays on the course After the course a visit was made to Canterbury Cathedral the first year to Haslemere Museum the second year and to Ightham Mote and Penshurst Place last year

Handicrafts—An interclub handicraft competition, including classes for sewing knitting, crocheting embroidering painting, basketry, woodworking etc is held every autumn Two challenge trophies have now been presented for this event.

Church service—Last year a service was

eld in Canterbury Cathedral which was attended by some two hundred of our club members

THE FUTURE

During the last years certain trends have been noticeable Wider and new interests have been aroused—a greater willingness to travel and to try new activities A greater wish to play a part in the life of the com munity has been observed A loyalty to their clubs is most noticeable in members

One wonders what people of 50 and 55 years of age today will expect in their clubs in 10 years' time What part will club leaders play then? Is there need for further development in these clubs for the elderly, which are now a part of the na tional life? Should or could members participate more themselves? Should we provide more opportunities for them to do so? Should we be content with, very often, our drab premises? Is there room for a greater variety of clubs to cater for different tastes and interests so that members could use their gifts and talents? What part could further education committees play in providing courses for some club members?

ACTIVITIES

All clubs arrange a number of outings during the year—to the sea, to churches, to cathedrals, to beauty spots, to historic houses, to factories, etc All clubs have a Christmas party, a carol service, an Easter service, and a harvest festival Most clubs have a minister of religion who interests himself in their activities Many clubs have a charity in which they interest themselves —such as the blind or deprived children Some clubs have a concert party which goes round to hospitals and homes and entertains the patients Many clubs have film shows provided by British railways or coach companies or private individuals All clubs greatly enjoy entertaining visitors from overseas Most clubs play dominoes, checkers, darts, and whist and other card games One club issues, and sells for 2*d*, a quarterly newssheet which gives items of interest about members and helpers and club activities generally This is particularly appreciated by club members when they are too frail to attend regular weekly meetings Some club members regularly visit sick members in hospitals Some clubs enjoy learning to make baskets The club leaders, week by week, listen to many stories of difficulties, often connected with housing and health, and their practical help and advice in these matters are greatly appreciated Many clubs receive gifts of clothes, dishes, and furniture These are usually sold, for very small sums, to members for the benefit of the club Some clubs have members represented on a committee Many club members belong to two or even more clubs Three members from one club served as models for the girls' grammar school, and one modeled for the art school Of course the tea provided by the helpers is greatly enjoyed at every club meeting and teatime is the highlight of the afternoon

INTERCLUB EVENTS

A number of interclub events—bulb shows, luncheons, holiday trips, etc.—are held each year

Bulb show—The clubs plant daffodils hyacinths, crocuses, tulips, scillas, etc., every autumn, and an interclub bulb competition is held each February Five challenge cups have been given for this event, and about thirty prizes are awarded annually in a number of different classes

Luncheons—Six members of each club are invited to a luncheon in the Civil Defense Hall in Sidcup about four times a year The meal is prepared by helpers, and members pay 2*s* each There is always a speaker, and slides are often shown This is one of the more recent activities and is rapidly growing in popularity

Holidays—Holiday schemes have been operating for some 9 years now Members are received in hotels in May and October at reduced prices and transport by coach is provided Last year a most successful holiday was arranged at Pitlochy in the Highlands of Scotland At least one club helper accompanies each party

Adult education—Through the co-operation of the Kent Education Committee, for the last 3 years about forty club members (drawn from all clubs) have attended a course of four afternoon lectures in the warm and comfortable library of the Adult Education Centre at Lamorbey Park The subjects have been local history, national history, historic homes, and the appreciation of music A coach picks up members at various points in the district and drives them to and from Lamorbey The members pay 6*d* each, and the committee meets the balance of the cost Last year—and again this year—three prizes were awarded for the three best essays on the course After the course, a visit was made to Canterbury Cathedral the first year to Haslemere Museum the second year and to Ightham Mote and Penshurst Place last year

Handicrafts—An interclub handicraft competition including classes for sewing knitting, crocheting embroidering painting, basketry, woodworking etc., is held every autumn Two challenge trophies have now been presented for this event.

Church service—Last year a service was

heating and other expenses are partly met by a subsidy from the local welfare department, which contributes 10 cents for each attendant. Therefore, all who attend have to sign an attendance list Sometimes the pastor of the parish makes some money available when there is a deficit The work of the men and women who are doing handicrafts at home (though the material is given by the club) is on display at a show from time to time, and, if the aged want these to be sold the profits go to the Association of Old People in case it provided the material

In this club (as well as in the other 22) the activities are mostly restricted to chatting playing cards chess, dominoes, checkers or shuffleboard, knitting or embroidering by women, preparation for the annual one-day trip some festivities, a show, occasional visits to sick colleagues, etc. The leaders have tried several times to introduce more cultural activities but mostly the members are not much interested They like to say, 'We are here for our pleasure, not to learn anything or to be really active At carnival time the people dress themselves up a little Sometimes there is a motion picture or popular music by an accordionist

Classical music and cultural films however, are in general not much liked Many old people want to talk with the leader about personal difficulties The old people do not assist much in serving tea collecting fees etc. Nor do they lead the club, as this would often cause jealousy or misunderstandings There are some magazines on display generally, the members look a little at the pictures but, if they want to read the articles they take them to their own homes

An attempt was made to organize a meals-on wheels service, but there was strong opposition to this idea A beginning has been made to visit occasionally an ill colleague or leader, and also occasionally one old woman goes once a week to another old woman to help her with the housekeeping The leaders also visit the sick old people

The oldest Catholic club has existed for 12 years, and the organization of clubs started about 1950

OTHER CLUB PROGRAMS

In the Protestant sector there are now at least 550 clubs, with an average membership of 30 The local clubs are more the result of local initiative by churches and less the result of a co-ordinated movement Meeting places for the clubs are clubrooms, village centers, vestries, or, occasionally, schoolrooms The club members are mainly working class people The leaders are mostly women (occasionally men) of middle age or younger Exceptionally, the leader is an older person

The finances come from the sponsoring churches and from the members (who each pays 10–25 cents a time) and often again from subsidies by the local welfare authorities on a fifty fifty basis In general, the club activities are of a simple character, consisting mostly of recreational activities At some places—as a rule, in the larger [illegible]

[illegible] availability of expert assistance and experience Thus there are some programs going on in which old people meet in a well equipped educational center and co-operate actively in setting up well defined club programs The latter activities are financed both by member contributions and by subsidies The tendency is to develop such programs

So again one can say that, though the general lines along which the clubs of old people in the Netherlands are developing are more or less the same and that at the moment these are still rather simple, there may exist considerable difference among the programs of geographically or denominationally closely allied clubs

12

Clubs for Older People in the Netherlands[1]

Old people's clubs may be originated both by church organizations and by non church societies There is no standardized club organization or program, though there are similarities among the various clubs The larger church denominations in the Netherlands each has an old people's organization which organizes clubs as well as other programs for older church members

The Catholics have the Union of Diocesan *Associations of Old People* with a membership of 40 000 Fees are 25 Dutch cents a month for a single person and 40 cents for a married couple Besides clubs, the associations organize retreats, stimulate mutual visits by older people to support each other spiritually and give advice on pensions and financial problems

Thus the club is only one of the activities of an association, but it also is the *focal point of many of the other activities* The Catholic clubs number about 350, with an average attendance at a club meeting of 50 The members are mostly from lower middle and working classes They are now attempting to reach upper middle-class people Membership is generally accepted at age 60 While the local branches of the diocesan associations are run by the older people themselves, leadership in the clubs *is generally* exercised by members of the Catholic women's organizations

[1] This account was prepared by Dr Robert J van Zonneveld of the National Health Research Council in The Hague Netherlands Dr van Zonneveld has made medicosocial studies of older people and is a leader in the field of gerontology in the Netherlands Since the majority of old peoples clubs in the Netherlands are sponsored by churches these have been described by him

The clubs are financed by dues from the members and by a subsidy from the local municipal government and occasionally from the church organization or from trade and industrial organizations

A LOCAL CATHOLIC PROGRAM

At The Hague, with 610 000 inhabitants, about a third of whom are Catholic, the Catholic Union of Diocesan Associations of Old People has 23 clubs, with about 1400 members Women may join at age 60, men, at 65 The members are mainly working class people

In one particular club the leader is a woman of about 60 assisted by six young *married women who are childless* She prefers such women since they have more spare time and are less tied down than women with children

This club meets two afternoons a week Many members arrive at noon while officially the club meeting starts at two o'clock or even later because *they* can save coal then by not using their stoves The meeting place is in a building of the Catholic church Other clubs meet in a youth clubhouse or in a parish house Attendance of this specific club is about 100 at a time They pay 10 Dutch cents each time they come for which they get three cups of coffee, tea or chocolate and a biscuit or a sweet (The minimum income the *state pension to which* with some minor exceptions every aged citizen is entitled, is 1584 Dutch florin a year for a couple and 972 florin for a single person) The costs for rent of the clubroom light,

Appearing in 1947, when the foundations of the British welfare state were being laid, the Rowntree Committee's report had almost the status of that of a Royal Commission and some of its recommendations were speedily made the object of legislation or of administrative action.

The committee found that the vast majority of old people present no problem at all to society—though more of them ought to seek a social solution of their problems The committee urged the building of small houses of special design for the old It called for a review of charities for the old some of which were ancient. It found that state pensions were sufficient to abolish acute poverty at current prices It suggested that large poor law institutions be abolished and that local authorities create several thousands of small homes Voluntary communal homes should be officially inspected Better provision was needed for the chronic sick More recreational facilities and clubs should be provided There should be financial inducements for fit people to stay at work if they wanted to beyond the age at which they were entitled to draw a pension. The recommendation to the Foundation was that it should set up a strongly endowed central body to study the changing needs and conditions, make experiments give advice and stimulate and support voluntary effort

One of the studies arising out of the Rowntree Committee's report was an intensive inquiry into the personal health and circumstances of the old people of Wolverhampton done by Dr J H Sheldon then director of medicine at the Royal Hospital in that town The report *The Social Medicine of Old Age*, was regarded as a minor classic

Sheldon found that only 3 per cent of the old people were undernourished and this was generally due to domestic circumstances Over 70 per cent of the men and women between the ages of 60 and 74 were able to enjoy unlimited movement outside their homes and even between 75 and 84 over half continued to do so

The small number of bedridden people at home (2 5 per cent) was probably due to the fact that most of them had been removed to institutions. The factors causing limitation of movement were shortage of breath, weakness, arthritis, vertigo, painful feet, and fear of traffic. Steep stairs lacking hand rails caused many accidents and impeded domestic work

About 60 per cent wore dentures, and 38 per cent who were without adequate teeth had no symptoms of indigestion About 40 per cent suffered from bronchitis and 55 per cent from pain in the feet, deafness was very prevalent, and liability to fall often due to vertigo, seemed to be connected with defective hearing A third of the poorer old people had unsatisfactory spectacles Over 80 per cent were normal mentally and a further 11 per cent were only slightly impaired About 3 per cent were eccentric, and nearly 4 per cent showed signs of mental breakdown

One of the most important conclusions was that old people living in their homes were more intelligent and cheerful than old people in institutions. The feeling of being necessary to the world gave them a sense of having something to do and was essential for the mental health of old people

About one-fifth of the old people suffered from loneliness, sometimes amounting to a desolation of spirit that was heart rending to meet. Widowers were lonelier than widows Of those living alone, nearly one-third had relatives within half a mile, and in 40 per cent of cases happiness and domestic efficiency depended upon the nearness of children and relations. Women up to the age of 75 and occasionally older were found to be helping with domestic tasks, including the rearing of grandchildren and gave more than they took in domestic responsibility

A survey of the health of the elderly at home was made in Sheffield by William Hobson, professor of social and industrial medicine at the University of Sheffield, John Pemberton, senior lecturer in the same subject, and a team of collaborators It

13

The Nuffield Foundation and the Study of Aging[1]

The Nuffield Foundation has taken a *continuous and intensive interest in the* problems of the old since its inception in 1943 Indeed, "the care and the comfort of the aged poor" is specifically prescribed by its trust deed This phrase has the ring *of orthodox Victorian philanthropy, but in* practice the Foundation has gone far beyond the prescription

The origin of its policies on aging is an appreciation of the national as well as the individual human problem In Britain the proportion of old people to the rest of the population is between two and three times greater than it was a century ago and is increasing as still more people are living into old age This does not necessarily mean that the rest of the community will have to support an increasing burden The *frontiers of real old age are being slowly* pushed back, and the theoretical retirement age could possibly be later than it is—60 for women, 65 for men But there are difficulties Industry is highly organized, machinery is complex and is constantly developing new forms, and industrial processes are continuous and set the pace for the worker The person who is slowing up mentally and physically and is irregular in attendance is the least desirable employee The social situation is also worsening for those old people who are not well or strong *enough to work or to look after themselves* for the tendency in a modern industrial society is for the extended family to scatter, leaving more old people unable to live with relatives and in need therefore of social help

In this situation the Foundation's policy has been (1) in general, to find out the facts about old people, (2) to discover what public and voluntary effort can do to *deal with their problems and to help the* voluntary bodies to do their share, (3) to encourage experimental psychologists to find out the capabilities of the aging how they can be taught to adapt to work, and how work can be adapted to their capacities, (4) to discover how particular industries actually deal with their aging workers and how they could do better, (5) to have the special medical problems of the old investigated and to encourage the establishment of special hospital departments and (6) to have the biological problems of *aging investigated by the best scientists* who can be attracted to the task

SOCIAL SURVEYS

On projects arising out of this policy the *Foundation has spent something like $6* million in the last 12 years It is possible in this review to mention only the most interesting of them

The first major creative act of the Foundation in the field of aging was to set up a committee under an eminent social investigator, the late B Seebohm Rowntree, to *inquire into the problems of old age* into the work being done, and into the resources available for the care of the old and to recommend what action should be taken by public and private bodies (the latter to include the Foundation)

[1] This account was prepared by John C Beavan assistant director of the *Nuffield Foundation*

Appearing in 1947, when the foundations of the British welfare state were being laid the Rowntree Committee's report had almost the status of that of a Royal Commission and some of its recommendations were speedily made the object of legislation or of administrative action.

The committee found that the vast majority of old people present no problem at all to society—though more of them ought to seek a social solution of their problems The committee urged the building of small houses of special design for the old It called for a review of charities for the old, some of which were ancient. It found that state pensions were sufficient to abolish acute poverty at current prices. It suggested that large poor law institutions be abolished and that local authorities create several thousands of small homes Voluntary communal homes should be officially inspected Better provision was needed for the chronic sick. More recreational facilities and clubs should be provided There should be financial inducements for fit people to stay at work if they wanted to beyond the age at which they were entitled to draw a pension. The recommendation to the Foundation was that it should set up a strongly endowed central body to study the changing needs and conditions make experiments give advice and stimulate and support voluntary effort.

One of the studies arising out of the Rowntree Committee's report was an intensive inquiry into the personal health and circumstances of the old people of Wolverhampton done by Dr J H Sheldon then director of medicine at the Royal Hospital in that town. The report *The Social Medicine of Old Age*, was regarded as a minor classic.

Sheldon found that only 3 per cent of the old people were undernourished and this was generally due to domestic circumstances Over 70 per cent of the men and women between the ages of 60 and 74 were able to enjoy unlimited movement outside their homes and, even between 75 and 84 over half continued to do so.

The small number of bedridden people at home (2 5 per cent) was probably due to the fact that most of them had been removed to institutions The factors causing limitation of movement were shortage of breath, weakness, arthritis, vertigo, painful feet, and fear of traffic Steep stairs lacking hand rails caused many accidents and impeded domestic work

About 60 per cent wore dentures, and 38 per cent who were without adequate teeth had no symptoms of indigestion About 40 per cent suffered from bronchitis and 55 per cent from pain in the feet, deafness was very prevalent, and liability to fall, often due to vertigo, seemed to be connected with defective hearing A third of the poorer old people had unsatisfactory spectacles Over 80 per cent were normal mentally, and a further 11 per cent were only slightly impaired About 3 per cent were eccentric, and nearly 4 per cent showed signs of mental breakdown

One of the most important conclusions was that old people living in their homes were more intelligent and cheerful than old people in institutions The feeling of being necessary to the world gave them a sense of having something to do and was essential for the mental health of old people

About one-fifth of the old people suffered from loneliness, sometimes amounting to a desolation of spirit that was heart rending to meet Widowers were lonelier than widows Of those living alone, nearly one-third had relatives within half a mile, and in 40 per cent of cases happiness and domestic efficiency depended upon the nearness of children and relations Women up to the age of 75 and occasionally older were found to be helping with domestic tasks including the rearing of grandchildren, and gave more than they took in domestic responsibility

A survey of the health of the elderly at home was made in Sheffield by William Hobson, professor of social and industrial medicine at the University of Sheffield, John Pemberton senior lecturer in the same subject, and a team of collaborators It

was found that, of those who were living on a state pension or on a pension supplemented by National Assistance benefit, 16 per cent of the married couples and 10 per cent of those living alone were below the standards of subsistence defined by the Beveridge Report, though the average incomes were up to this standard

The group whose position was most unsatisfactory was those who had only a state pension and had not applied for supplementary National Assistance, perhaps through ignorance or prejudice Dental conditions were unsatisfactory, but, since the provision of the National Health Act, more people had adequate spectacles About 20 per cent of the men were still in whole-time work, and it seemed that it was easier for the professional or managerial worker or the unskilled worker to stay at work than it was for the skilled workers to do so These researchers found that 29 per cent of those aged 65–74 who had retired were fit It seemed fairly certain that at least one third of retired men between the ages of 65 and 74 could continue in whole time employment if they wished and if suitable employment were available

Another important investigation was made some years later in the late fifties by Peter Townsend and published in his book, *The Family Life of Old People* Townsend based his observation on old people selected at random in Bethnal Green, an old working class area of London In an area like this— which is probably not typical— Townsend found that comparatively few old people were seriously isolated Each old person had on average thirteen members of an extended family living within a mile and kept in touch with most of them Elderly women got a good deal of help from their relatives, but they did what they could to help in return by looking after grandchildren and providing midday meals About two fifths of them were infirm or living with an infirm spouse and one in three had been in hospital within the last 5 years One in eight had caused a relative to give up paid work in order to look after them

Townsend suggested that, to help the family in its task of supporting the old, there should be a comprehensive family-help service to experiment with alternatives to institutional care—boarding out the isolated and converting old houses into one-room flats with housekeepers in charge The existing home help arrangements should be extended to relieve relations in the evening and for holidays A health visitor with nursing qualifications could do much to prevent the gradual deterioration in old people, and interest in life could be preserved by old people's clubs and unofficial friendly visiting by volunteers Physiotherapy in the home might have a useful future

Townsend is now making a study of the institutional care of the aged and is attached to the London School of Economics

Although so much has been done to get at the medical and social facts of old age, little is known about the income and expenditure of elderly people The Department of Applied Economics at Cambridge made a pilot survey in 1957 to look at this problem in a selected area and to find out what old people were earning from part time work or receiving by way of private pensions, encashment of savings, and help in money or kind from relatives They also found out something about the spending and saving behavior of the elderly The pilot study was encouraging and the Foundation made a grant to extend the investigation to other areas

In Britain unlike the United States the organization of classes and groups for "senior citizens" is not a recognized part of education although in fact, some people do prepare for retirement by using educational facilities to learn domestic craft or arts or to equip themselves for social or political activities The Foundation made a grant to the National Institute of Adult Education to collect information about the existing facilities, the use made of them, and the general role played by adult ed

ucation in helping people to adjust them selves to retirement and to continue leading an active life The report is to be completed soon.

THE NATIONAL CORPORATION FOR THE CARE OF OLD PEOPLE

The Foundation followed the advice of the Rowntree Committee and set up in the same year (1957) the National Corporation for the Care of Old People The Foundation put in $1 5 million to equip it for the next 5 years, and the Lord Mayor of London s National Air Raid Distress Fund, which had been financing old peoples' homes in bombed areas, gave the corporation an equal sum. It also attracted a grant of $500 000 from the gift which the peoples of South Africa made to Britain and took over the administration of other trusts with total resources of $1 million

In the beginning most of its money went into the provision of voluntary homes for relatively able-bodied people needing care and attention But as the local authorities implemented the National Assistance Act, which enjoined them to provide such homes, the corporation began to look for other ways in which voluntary bodies could help old people It helped to establish 1200 non-residential clubs for old people, a cheap laundry service in the city of Bristol, a chiropody service (to keep old people literally on their feet), a system to bring cooked meals to old people living alone, and a system of night sitters in There was public accommodation for the elderly sick and for the elderly able bodied, but there was no provision for those who were neither well nor sick The corporation helped to provide six rest homes to show how the gap could be filled and insisted they should have a proper link with hospitals with geriatric units. For its new work the Foundation provided a further $750 000, and recently it has renewed the grant at the same rate

The next phase in the corporation's work was concerned with the care of old people at home and finding out how they could best be helped to remain there Many old people were unaware of the services available to them to help to keep their independence The corporation tried to discover how many applicants for places in communal homes would really have need to move if they made full use of the domiciliary services It appointed, in three areas, social workers to visit the old people who had asked advice about moving out of their own homes In another town an intensive study was made of the use old people were making of social services and of what additional ones were needed It also ran a night attendance service for those who were acutely ill and in need of institutional care which was not immediately available

Although the corporation felt that it was generally desirable to keep old people in their own homes, it did however make preliminary investigations into comparative costs and found that occasionally it cost a good deal more to provide services enabling them to stay at home than to take them into hospital The corporation is still stressing the need to keep as many old people as possible within the community to which they have been accustomed and is urging public bodies to provide more housing for old people It is busy at present trying to close the gap between those doing research into the problems of aging and those engaged on practical work with the old so that they benefit from each other's experience

SOME PRACTICAL EXPERIMENTS

The Nuffield Foundation has always worked in close collaboration with the Nuffield Provincial Hospitals Trust. Indeed, the chairman of the Foundation, Sir Geoffrey Gibbs, is chairman of the Trust and also of the National Corporation for the Care of Old People The director of the Foundation, Leslie Farrer Brown, is a governing trustee of the Trust and is honorary secretary to the ordinary trustees He is also a governor of the National Corporation The Trust's main concern in recent years has been to investigate the

was found that, of those who were living on a state pension or on a pension supplemented by National Assistance benefit, 16 per cent of the married couples and 10 per cent of those living alone were below the standards of subsistence defined by the Beveridge Report, though the average incomes were up to this standard

The group whose position was most unsatisfactory was those who had only a state pension and had not applied for supplementary National Assistance, perhaps through ignorance or prejudice Dental conditions were unsatisfactory, but, since the provision of the National Health Act, more people had adequate spectacles About 20 per cent of the men were still in whole time work, and it seemed that it was easier for the professional or managerial worker or the unskilled worker to stay at work than it was for the skilled workers to do so These researchers found that 29 per cent of those aged 65–74 who had retired were fit It seemed fairly certain that at least one third of retired men between the ages of 65 and 74 could continue in whole-time employment if they wished and if suitable employment were available

Another important investigation was made some years later in the late fifties by Peter Townsend and published in his book, *The Family Life of Old People* Townsend based his observation on old people selected at random in Bethnal Green, an old working class area of London In an area like this— which is probably not typical—Townsend found that comparatively few old people were seriously isolated Each old person had on average thirteen members of an extended family living within a mile and kept in touch with most of them Elderly women got a good deal of help from their relatives, but they did what they could to help in return by looking after grandchildren and providing midday meals About two fifths of them were infirm or living with an infirm spouse, and one in three had been in hospital within the last 5 years One in eight had caused a relative to give up paid work in order to look after them

Townsend suggested that, to help the family in its task of supporting the old, there should be a comprehensive family-help service to experiment with alternatives to institutional care—boarding out the isolated and converting old houses into one-room flats with housekeepers in charge The existing home help arrangements should be extended to relieve relations in the evening and for holidays A health visitor with nursing qualifications could do much to prevent the gradual deterioration in old people, and interest in life could be preserved by old people's clubs and unofficial friendly visiting by volunteers Physiotherapy in the home might have a useful future

Townsend is now making a study of the institutional care of the aged and is attached to the London School of Economics

Although so much has been done to get at the medical and social facts of old age, little is known about the income and expenditure of elderly people The Department of Applied Economics at Cambridge made a pilot survey in 1957 to look at this problem in a selected area and to find out what old people were earning from part-time work or receiving by way of private pensions, encashment of savings, and help in money or kind from relatives They also found out something about the spending and saving behavior of the elderly The pilot study was encouraging and the Foundation made a grant to extend the investigation to other areas

In Britain, unlike the United States, the organization of classes and groups for "senior citizens" is not a recognized part of education, although in fact, some people do prepare for retirement by using educational facilities to learn domestic craft or arts or to equip themselves for social or political activities The Foundation made a grant to the National Institute of Adult Education to collect information about the existing facilities, the use made of them, and the general role played by adult ed-

trated on research As long ago as 1946 the Foundation set up a Nuffield Research Unit in problems of aging in the Psychological Laboratory of the University of Cambridge under Professor Sir Frederic C. Bartlett F R S and after his retirement under A T Welford Its main job has been to study changes of human performance in middle and old age likely to have a bearing on capacity for work in industry

Most of the work consisted of laboratory experiments to compare the performances of people at different ages from the twenties to the seventies at tasks which may be termed skilled The laboratory work was supplemented by the study of industrial

man Skill (Oxford University Press) The team found that the well known slowing of performance with age is not due to old peoples being physically incapable of moving faster but to their taking longer to perceive what has to be done to their brains requiring more time to control their muscles and to their tending to exercise more care and caution than younger people The changes of perception with age appear to be far greater than can be explained by age deterioration of sight though factors such as good lighting are still very important.

It is in jobs which call for fast light manipulative work that one sees most clearly the increased time that older people take in perceiving and relating what is perceived to what is done This kind of job often becomes difficult some 5 or 10 years before heavy muscular work does Again older people may find that although the mechanization of their job may reduce the physical burden it replaces one kind of difficulty by another because it substitutes arbitrary complex control actions for the simple direct eye-hand co-ordination of manual work

One of the most important ways to make work more suitable for older people is to organize it so that it is straightforward and free from complications as well as reducing the muscular effort required Examples are given in the book which open up the possibilities of greatly improved methods for training or retraining people in middle or old age

The studies done by this unit are the most extensive series undertaken anywhere in the world on age changes in performance On the whole old people show up rather well Although age takes its toll in many ways its effect is shown often to be of little importance and even when it does make a substantial difference older people are seen again and again to change their manner of work to make the best use of their abilities

It was appreciated that the results of research on the employment of older people must be tested on the shop floor and a grant was made to K F H Murrell joint honorary secretary of the Ergonomics Research Society to do such field experiments from the Department of Psychology at the University of Bristol The first activities were mostly concerned with confirming that aging affects performance on the shop floor and a study was made of the age structure of engineering jobs throughout the country The broad conclusion was that the hierarchy of jobs is determined by their difficulty with the older worker doing the simpler tasks

A study of accidents was also made and it was found that older men working on the jobs usually given to younger men suffered more personal accidents The unit then tried to discover by means of job analysis what the typical job functions were that militated against the older worker In general it appeared that the complexity of a job was to be related to such things as the proportion of the available controls people had to operate the amount of stooping and the amount of vision that was required

For the last 18 months the unit had people doing simulated tasks in the laboratory

working of the National Health Service and to undertake experiments which might point the way to its improvement The Trust too has been concerned with the care of the aged It has provided an occupational day center for the elderly at Nottingham in the hope of preventing by simple measures mental and physical breakdown The principle is to arrange for elderly people who are showing signs of instability, daily or frequent attendance at the center where in the atmosphere of a social club they can feel that they are wanted There are facilities for modest creative work, indoor and outdoor, and a good meal is provided The center is run by the Health Committee of the City Council

At Belfast the Trust and the City Hospital experimented with the home care of the elderly It was believed that there were elderly invalids, well cared for at home whose recovery was delayed or who even risked being disabled or becoming bedfast through lack of facilities which are usually available only in hospital

Patients were selected for treatment in consultation with their family doctors and often physiotherapy was given About two thirds of them made satisfactory progress and usually at a lower cost than if they had gone to the hospital

The Trust has also sponsored a sociological and medical sample survey of old people in northeastern Scotland which is being carried out by the Department of Social Medicine at Aberdeen The department hopes to examine some aspects of old age which have not been sufficiently explored It is likely that attitudes and behavior in later life are largely the outcome of experience in earlier years So an attempt will be made to relate family occupational, and other past influences to the problems of the present.

At Cowley Road Hospital, Oxford, there has been a combined operation by the Foundation, the Trust, and the National Corporation to help the Oxford Geriatric Unit, under Dr L Z Cosin A combination rest home and day hospital has been provided and has been designed by the Division for Architectural Studies, another unit which is housed with the Foundation and the Trust at Nuffield Lodge, London and is supported from Nuffield funds

The rest home, Hurdis House is a forty bed annex of the unit where convalescent patients waiting to go home or into local authority homes can be rehabilitated This often cuts down their stay in the acute wards of the hospital and the costs of care The idea is to replace the antiquated concept of custodial care of old people by that of continuing care, which implies that a program of medical care does not begin when a patient enters hospital or end when he is discharged

Many Oxford family doctors have found that day hospital care for elderly patients is the answer to their environmental problems There is useful co-operation between family doctors and the hospital's medical and auxiliary staff, and there are joint discussions on treatment Arrangements have also been made with the public health authority for bringing in the mental health visitors and it is hoped that one result will be that cases of mental disability will be received earlier

A Nuffield mental health research team has operated from this unit for 3 years and has assessed the improvement of social behavior in a group of deteriorating old men in a local authority home This has led to permanent programs of occupation being provided for them An evaluation has been made of the relative load of mental health work done for the elderly by the local mental hospital and the Geriatric Unit (the unit was found to be dealing with 75 per cent of the mental health problems) A close study was done of fifty permanently confused old people and their social background and an evaluation was made of the function of occupational therapists

ELDERLY PEOPLE AT WORK

While the social aspects of aging have been the concern of the National Corporation, the Foundation itself has concen

trated on research As long ago as 1946 the Foundation set up a Nuffield Research Unit in problems of aging in the Psychological Laboratory of the University of Cambridge under Professor Sir Frederic C. Bartlett FRS and after his retirement under A T Welford Its main job has been to study changes of human performance in middle and old age likely to have a bearing on capacity for work in industry

Most of the work consisted of laboratory experiments to compare the performances of people at different ages from the twenties to the seventies at tasks which may be termed skilled The laboratory work was supplemented by the study of industrial

man Skill (Oxford University Press) The team found that the well known slowing of performance with age is not due to old people s being physically incapable of moving faster but to their taking longer to perceive what *has to be done* to their brains requiring more time to control their muscles and to their tending to exercise more care and caution than younger people The changes of perception with age appear to be far greater than can be explained by age deterioration of sight though factors such as good lighting are still very important.

It is in jobs which call for fast light manipulative work that one sees most clearly the increased time that older people take in perceiving and relating what is perceived to what is done This kind of job often becomes difficult some 5 or 10 years before heavy muscular work does Again older people may find that although the mechanization of their job may reduce the physical burden it replaces one kind of difficulty by another because it substitutes arbitrary complex control actions for the *simple* direct eye-hand co-ordination of manual work

One of the most important ways to make work more suitable for older people is to organize it so that it is straightforward and free from complications as well as reducing the muscular effort required Examples are given in the book which open up the possibilities of greatly improved methods for training or retraining people in middle or old age

The studies done by this unit are the most extensive series undertaken anywhere in the world on age changes in performance On the whole old people show up rather well Although age takes its toll in many ways its effect is shown often to be of little importance and even when it does make a substantial difference older people are seen again and again to change their manner of work to make the best use of their abilities

It was appreciated that the results of research on the employment of older people must be tested on the shop floor, and a grant was made to K F H Murrell joint honorary secretary of the Ergonomics Research Society to do such field experiments from the Department of Psychology at the University of Bristol The first activities were mostly concerned with confirming that aging affects performance on the shop floor and a study was made of the age structure of engineering jobs throughout the country The broad conclusion was that the hierarchy of jobs is determined by their difficulty with the older worker doing the simpler tasks

A study of accidents was also made and it was found that older men working on the jobs usually given to younger men suffered more personal accidents The unit then tried to discover by means of job analysis what the typical job functions were that militated against the older worker In general it appeared that the complexity of a job was to be related to such things as the proportion of the available controls people had to operate the amount of stooping and the amount of vision that was required

For the last 18 months the unit had people doing simulated tasks in the laboratory

in order to find out more clearly how people perform at work as they grow older. A study is being made of training in relation to age.

An effort was made to discover what had happened to a number of men who in middle life had left highly complex jobs. Although some had elected to change to less skilled jobs, the main trend was to find the same kind of job but in a smaller firm.

Meanwhile Dr. J. Szafran, lecturer in psychology at the University of Exeter, who was Mr. Welford's assistant director at Cambridge, is studying the effects of aging on the performance of tasks of varying complexity. Much recent work implies that in the analysis of human performance the amount of both "information" or "organization" being delivered to the human operator should be considered rather than the "load" he is supposed to deal with. What Dr. Szafran is aiming at is a closer analysis of the effects of aging on two components of complexity—the information content and the discrimination difficulty. One of the surprising conclusions suggested by the results so far available is that the older adult may be as efficient as the younger in making rather elaborate decisions, although lagging behind in the simpler discriminations and choices. These findings may provide some justification that with age there is an increasing level of random activity in the central nervous system.

FACTORY PROBLEMS

Over a number of years F. Le Gros Clark has been doing for the Foundation an investigation of the social aspects of the continued employment of elderly workers. He has published a series of short studies on the extent to which various kinds of modern industry can absorb the labor of aging persons and the social and traditional influences that really determine the attitude of management, including foremen and welfare and personnel managers.

Le Gros Clark began with a study, *Older Men in the Building Industry*, which dealt with 320 men, all apparently fit at the beginning of the study, from the age of 60 to the end of their working lives. Clark found that, of every 100 men fit at 60, about 70 were still fit as building workers 5 years later. At 70 about 30 of the original 100 were still working.

In the later sixties many men had to quit as a result of degenerative complaints such as rheumatism or bronchitis. At least 17 per cent of them went back to work too soon after a serious illness and retired a few months later. Measures of rehabilitation might have given them a few more years at work. About three-quarters of the men over 60 did not want to, or would not, work at heights. More than 40 per cent refused jobs calling for speed, and 20 per cent were reluctant to work in bad weather.

But about a third of the whole labor force is engaged on repair and maintenance work with a slower tempo, and foremen say that they can employ twice as high a proportion of older men as they can have on new-building sites. Clark suggested that older men should change over to such work in time to adjust themselves to it. This industry is fairly well adapted to give older men a chance of employment, provided that they are carefully distributed.

In *New Jobs for Older Workers*, Clark found that about 20 per cent of the men who reach their early sixties in reasonable health will need lighter jobs before they pass beyond their mid-sixties.

With Agnes C. Dunne, Clark did a more comprehensive study called *Aging in Industry*, covering 32 jobs. This showed that 70 per cent of carpenters, bricklayers, and foresters carry on well into the late sixties, since they are able to adjust pace to age, and that 60 per cent of dockers, plasterers, bargemen, warehouse men, and welders can also carry on to this age but that only 40 per cent of foundrymen, bus conductors, bus-drivers, truck-drivers, and paperworkers can do so.

Such industries as bricks, glass, boots and shoes, cabinet-making, and paper show a greater tendency than they used to show to lose operatives around their mid-sixties.

Most old time craftsmen, such as watchmakers and makers of musical instruments, remain on their jobs until a late age

Each year probably 40,000 elderly men who are still reasonably fit will need alternative work, and it is doubtful whether sufficient suitable jobs are available Clark thinks that appeals to industry are not sufficient, because most industries are not flexible enough to absorb more than a small proportion of their own aging workers He suggests that various social agencies should be established for the purpose and reminds us that only under conditions of high employment will the matter be taken seriously

In a trade recession the older men are the first to go (we had experience of this in the recession of December, 1958) In 1957 Clark published a further study, *Ageing on the Factory Floor*, an inquiry into the prospects of aging men with a mechanized industry the production of domestic furniture The report concludes that some working adjustments or concessions had to be made to one man in ten in their late fifties, three in ten in their early sixties, and six in ten in their late sixties.

Le Gros Clark's most recent study *Age and the Working Lives of Men*, states that one of the problems of industry and of the nation is that of the aging man whose job is getting beyond him. In most cases he *is* by no means finished, but, if he is to go on in paid employment, he has either to take his job more easily or find a new one This investigator has tried to calculate how many men are in this difficult transitional stage The evidence is incomplete but he estimates that by the age of 65, about 10 per cent of manual workers have become chronic invalids and have *retired*, about 20 per cent are no longer holding *down* their normal jobs but have either moved to a lighter job or need to do so at once al most three out of four of those who need to change their jobs retire around 65 after an unsuccessful attempt, not always a very pertinacious one, to find a more suitable job, and 12 per cent or more retire at 65 by custom or inclination, though in theory they might have gone on working

On the whole, Le Gros Clark concludes that able-bodied men in their sixties need not be a problem for industry The real difficulty arises with those who are compelled by their age to work less strenuously, for often the system of production leaves few jobs suitable for elderly workers.

THE BIOLOGICAL APPROACH

The Foundation has for many years made biology its foremost interest in the sciences, and a good deal of the fundamental research in this field is indirectly linked with the process of aging Some, however, of these studies have been directly linked with the process With the co-operation of the Royal Society, the Foundation established gerontological research fellowships of professional status The first two Fellows appointed under the scheme were Dr P L. Krohn, of Birmingham, designated Nuffield Professional Research Fellow, and Dr D A Hall at Leeds Dr Hall has been making experiments to substantiate his somewhat controversial belief that an elastin like substance is prepared by the [illegible]

place in the aging ovary and has been grafting tissues between old and young mice which were all closely related members of one inbred strain He discovered that *oestrous* cycles may be restored in anoestrous old mice by grafting young ovaries. It appears, therefore, that changes in the ovary itself are primarily responsible for the failure of the reproductive processes The aging process in the ovary is manifest as a progressive loss of *oöcytes*, that is, of the egg cells before they have *reached* maturation Professor Krohn has shown that this process can be retarded by removing the pituitary Animals have been treated in this way, and their ovaries have been removed at an age when they would ordinarily have lost their reproductive capacity When such ovaries are transplanted

in suitable young hosts, they can still give rise to pregnancies

In the Department of Physiology at St Bartholomew's Hospital, Professor K J Franklin, F R S, made a plan of research along broad lines, dividing human life into four phases conception evolution maturation, and involution This provided for an exploration of the physiology of aging from conception to death, with sample experiments along the line rather than over a small portion of the life span Studies have been made of the mechanism of parturition and renal physiology at various ages and of the reactivity of the gingival epithelium on short lived animals The department has also investigated thyroid activities in rats of different ages, renal function following hypotension and the aging effects of ionizing radiations on rats and mice This last has become the most important activity and has significance for cancer research It looks as though the effects of radiation persist in subsequent generations

The Geriatric Unit at Sunderland General Hospital has for some years been studying physiological and pathological changes in the aged and aging A phenomenon found in almost all aging tissues is shrinkage, and in this process changes in content of water and electrolytes take place insidiously The unit has been studying the reversible and irreversible effects of these changes on kidneys the heart, and the brain

Its recent work has concerned a group of young subjects suffering from degenerative diseases of the central nervous system, and it has been found that a chronically ill person of 40–50 years has the body water distribution of a normal person of 70–80 years An attempt has also been made to investigate protein absorption in the aged To extend knowledge of the metabolism of normal pathological aging the unit has studied serum lipids and lipoproteins in normal young people, schizophrenics, arteriosclerotics, and sufferers from coronary artery disease Some of the findings were reported at the first meeting of the European Clinical Section of the International Association of Gerontology, which took place in Sunderland last year

In the Department of Zoology at University College, London Dr Alex Comfort, Nuffield Research Fellow in Gerontology, has been engaged for some years on an expanding program of research into the biological problems of aging He is seeking information about the pattern of aging in vertebrates other than man and laboratory rodents The work he has now in hand includes a long term study of the actuarial aging of fish under various conditions of growth in order to see whether their behavior differs from that of mammals and whether retardation of growth also produces prolongation of life

In the same department Dr J Maynard Smith has studied the process of aging in the *Drosophila* fly finding that the life span of the insect is roughly halved for each degree rise in temperature, over a range from 20° C (3 months) to 35° C (25 minutes) This relationship between temperature and life span suggested that causes of senescence at normal temperatures and the causes of death at high temperatures might have something in common

THE FUTURE

The technique of the program—looking at a large and complex problem from a variety of angles personal social industrial, medical and biological—is one which a foundation is peculiarly well placed to use It is a fruitful technique for it may indicate from time to time not only what the solution of a recognized problem may be but also what the new problems are and what their degree of urgency is

The study of aging is one of the Nuffield Foundation s original interests It is of course, an enduring one The more we learn about aging the more we see we have yet to learn

14

The Condition of the West German Pensioner before the Social Reform[1]

In Germany in the last decade as in other countries of Western industrial society the life-span of persons of advanced age has become a problem which has evoked a lively scientific and a still more animated public discussion The topic of this discussion was in particular the system of the financial care of the aged workers and the compulsory insured employees whose state fixed pension in view of the mounting living standards of the gainfully employed became ever more unsuitable and turned people on social security into an under privileged and needy group

In connection with the plans of the federal government for social reform H Achinger J Höffner H Muthesius, and L Neundorfer submitted an expertise (*A New Ordering of the Social Services* [Cologne Greven Verlag]) which tried to proceed from social facts as well as these could be ascertained At the same time the authors complained of the scarcity of knowledge of the social reality of the older workers and employees and asserted that a successful reorganization of the social security system seemed hardly possible without such knowledge

Thanks to the efforts of Neundorfer and Achinger in conjunction with G Mackenroth the Association of Research Social Science Institutes with the financial support of the German National Science Foundation began a common research project in 1954 which was supposed to furnish the material facts on the condition of the pensioners on the conception of old age and on the provision for older workers and employees

According to the research proposal of Neundorfer it was not the amount of the pensions (which were imperatively in need of being increased) or the procedure of their calculation and payment (complicated hard to understand and time-consuming) which was to be the subject matter of the study Rather it was to be an investigation of the significance of other sources of the maintenance of the pensioners such as ownership of houses real estate and garden income-producing activities additional pensions and public assistance as well as support by younger members of the family in the joint household The working hypothesis was that the old age pension of public social insurance had lost its dominant role as a source of support in the last 50 years Furthermore the investigation aimed at eliciting the differences between the condition of the pensioners in urban and in rural communities According to a second hypothesis the opportunity for a full and secure life in old age should be greater in the country than in the city

In order that the substantive and methodological experiences and interests of the separate institutes be better utilized the study group decided not to conduct a unified regionally subdivided investigation by

[1] This account of a research project of the Association of Research Social Science Institutes was prepared by Ludwig von Friedeburg Institut fur Sozialforschung an der Johann Wolfgang Goethe Universität, Frankfurt am Main

which all institutes used the same methods but rather to divide the research project into a series of single co-ordinated studies The co-operation between the institutes should be limited to an occasional exchange of experiences, and the findings of the sep arate studies would be later co ordinated into a complete report

Of the suggested single themes, the fol lowing were worked on principally in the year 1955 I Berghaus and I F Poser, Institute for Economics and Sociology in the Federal Research Institution for Home Economics, Bad Godesberg, carried through a "Comparative Investigation of 510 House *holds of Pensioners in City and Country* with and without Home Production," in which they studied both the meaning of *family ties for economic subsistence and* the personal satisfaction of the pensioner W Brepohl, Social Research Institute of Dortmund investigated the "style of life of pensioners" with like pensions and like family conditions, in which 200 couples of pensioners were investigated stratified as to rural and urban communities and region of the Federal Republic H J Seraphim and F J Hessing, Institute of Homestead ing and Home Economics Munster Uni versity, investigated in metropolitan areas "the significance of the small garden from the standpoint of social security by way of a statistical analysis of 40 000 small gardeners and by personally interviewing *260 of these*

O Neuloh, Social Research Institute Dortmund, was concerned with the eco nomic and social situations of aged miners and their pension system and interviewed 300 pensioners in the Ruhr district. Neun dorfer, K G Specht, and S Groth, Socio graphical Institute, Frankfurt, used mono-graphs to compare "men in retirement from railway, mailpost, and industry," the con dition of the pensioned small civil servants, with that of the pensioners of the general public old age insurance in urban and rural communities

In contrast with the forementioned stud ies, which were concerned with pensioners, L von Friedeburg and F Weltz, Institute of Social Research, Frankfurt, attempted in their study of the conceptions of aging and the provisions for old age of workers and employees to investigate the economi cally active who were expecting to receive a pension in their old age Their findings are based on questionnaires of a representa tive sample for the Federal Republic of 1000 cases of male employed persons of non agricultural occupations between the ages of 20 to 65 years who are members of the disability or employee insurance and upon 348 interviews with wives of the in terviewed workers

During the course of the investigation the representatives of the institutes met twice for a discussion of the entire research *project At the end of the investigations* each institute submitted a research report (usually mimeographed) of its part of the study The first published report on the study of the Institute for Social Research, by Friedeburg and Weltz, was *The Con ception of Aging and Provisions for Old Age* (Frankfurt Europaische Verlagsan stalt, 1958) This was followed by the findings of the study of the Institute of Homesteading and Home Economics by F J Hessing on *The Economic and So cial Significance of the Small Garden* (Mun ster Verlag Joseph Kiekenbeck 1959) The plans of a projected publication of a complete report integrating the individual *studies have not been realized* as yet in view of the changed conditions in the so-cial pension system through the reform legislation in 1957

Owing to the division of the general project into loosely connected individual studies, the rich and varied material and the results of the different investigations on the condition of pensioners before pen sion reform are difficult to compare and to integrate into a representative picture If one, nevertheless attempts a summari zation of the findings with respect to the research objectives of the total project, it appears that the two working hypotheses have been disproved The old age pensions

of social insurance grossly insufficient as they may have been before the reform had nevertheless their importance as the main source of subsistence even for the minority of those pensioners who had a significant source of additional income It was the amount of the pensions (apart from the state of health) that was the major source of concern of the old retired worker and employee as well as of the young and still gainfully employed worker so far as the latter was at all concerned with the problems of old age Material need and a poor state of health made all the other problems of old age look insignificant—problems arising from the loss of function of the no longer employed old member of the developing industrial society loneliness boredom, and loss of prestige

These questions which are the major concern of the gerontologist can only now after the pension reform of 1957 which decisively bettered the economic situation of the pensioner become really significant and adequately investigated In view of the acquiescing helplessness of the aged and the ignorance of the young it can be shown that up to now every provision is missing to prepare a person for the role of pensioner assigned to him by society namely to lead his life for himself alone

The second working hypothesis also could not be substantiated in its general application namely that the pensioners in the country have more opportunities for a full and secure life. Certainly pensioners who own houses and lands are better off (and they are found more often in small communities than in the large cities) but pensioners who live in the country without such property are as a rule worse off than comparable groups in the city

The second working hypothesis was mainly oriented to the advantages of the living together of the generations under one roof of a single household Yet the conception that the family is responsible for the old and offers them social security makes the assumption of the persistence of the intact large family functioning as a solidified community, a survival which has more and more vanished in the course of industrial evolution

The findings of the investigations show that the dwelling together of at least two adult generations only seldom occurs and that it is not basically desired and included in the self planning by the vast majority of workers and employees Therefore the recommendation for a dwelling and economic policy of the restoration of the large family can hardly lead to a practical social political initiative In addition the expansion of public provision by the increase in state pensions will not mechanically curtail the efforts of individuals to make their own preparations for old age or on the other hand to be stimulated automatically by the restriction of the governmental policy of assistance and the support of primary insurance societies

It is much more apparent that the initiative for the care of the individual and of the family depends decisively upon the assumption of basic risks by the state and on the assurance of being able to plan ahead for a longer time without risk A social policy which plans and secures its standards from the state will therefore promote self-care more strongly than a direct appeal to the initiative of the individual and his support by private acquisition of property As soon as to be sure the governmental planning shall make from its duty of guardianship an equal responsibility for all citizens irrespective of their personal financial preparation it would have to surmount the opposition of traditional conceptions of the individual's participation which has to be honored according to performance These findings explain even at the time of the investigation the clear vote of the workers and employees for the system of German social insurance although their inadequate pensions were sharply criticized.

PART THREE

Selected Statistical Tables

Comparative Data on Socioeconomic Conditions and the Aging in Different Countries

A wealth of statistical data is available for comparing the countries of the world on the aging population and on the social economic conditions affecting their status and welfare The most important sources to be consulted by students on the com parative study of aging are the following the *International Labour Organization Year book* the *United Nations Demographic Yearbook* the *United Nations Statistical Yearbook* and the *World Health Organi zation Yearbook*

The selected tables in Part III are presented for gerontologists who may wish ready reference to data on other countries besides those given in the chapters of this volume The tables do not cover all the countries of the world. They do include all the European countries—Communist and non-Communist—except the smallest countries, such as Albania, Luxembourg, and Monaco In addition, data are presented for four non European countries of Western culture—Australia, Canada, New Zea land, and the United States—and four relatively underdeveloped countries—Brazil and Mexico in the Western Hemisphere and Egypt and India in the Eastern Hemisphere.

The inclusion of countries outside West ern culture gives evidence of the wide dif ferences among the nations of the world in their social and economic characteristics which affect the aging of their populations

Comparisons between countries need to be made with great caution, owing to na tional differences in methods of census-taking and in definitions of terms Many of these discrepancies are described in de tail in the original sources of these tables.

TABLE 1*

Area, Density, Population, and Latest Population Estimate

Country	Date of Census	Total Population	Estimate Midyear 1957 Population (in Thousands)	Area (Km²)	Density (1957)
Austria	1951	6,933,905	6,997	83,849	83
Belgium	1947	8,512,195	8,989	30,507	295
Bulgaria	1956	7,600,525	7,667	111,493	69
Czechoslovakia	1950	12,338,450	13,353	127,859	104
Denmark	1955	4,448,401	4,500	43,042	105
Finland	1950	4,029,803	4,336	337,009	13
France	1954	42,843,520	44,091	551,208	80
East Germany	1950	17,199,098	16,401	107,431	153
West Germany	1956	50,974,500	51,469	247,960	208
Greece	1951	7,632,801	8,096	132,562	61
Hungary	1949	9,204,799	9,815	93,030	106
Ireland	1956	2,898,264	2,885	70,283	41
Italy	1951	47,158,738	48,483	301,226	161
Netherlands	1947	9,625,499	11,021	32,450	340
Norway	1950	3,278,546	3,494	323,917	11
Poland	1950	25,008,179	28,300	311,730	91
Portugal	1950	8,441,312	8,909	92,200	97
Rumania	1956	17,489,450	17,829	237,500	75
Spain	1950	27,976,755	29,431	503,486	58
Sweden	1950	7,041,829	7,367	449,682	16
Switzerland	1950	4,714,992	5,117	41,288	124
United Kingdom	1951	50,225,224	51,657	244,016	212
England and Wales	1951	43,757,888	45,043	151,113	298
Northern Ireland	1951	1,370,921	1,399	14,139	99
Scotland	1951	5,096,415	5,211	78,764	66
Yugoslavia	1953	16,990,617	18,005	255,804	70
U S S R	1939	170,467,186	200,200	22,403,000	9
Australia	1954	8,986,530	9,643	7,704,159	1
Canada	1956	16,080,791	16,589	9 974 375	2
New Zealand	1956	2,174,062	2,229	267 995	8
United States	1950	150,697,361	171,196	7,827,976	22
Brazil	1950	51,976,357	61,268	8 513 844	7
Mexico	1950	25,791,017	31 426	1 969 269	16
Egypt	1957	22,992,150	24,026	1 000,000	24
India	1951	356,741,669	392,440	3,291,769	120

* Source *United Nations Demographic Yearbook 1958* Table 1

*TABLE 2**

PERCENTAGE OF PERSONS AGED 65 AND OVER OF ALL PERSONS OF THE SAME SEX IN OR AROUND 1850, 1900, AND 1950

COUNTRY	MALE			FEMALE		
	1850	1900	1950	1850	1900	1930
Austria		4 7	9 5		5 3	11 5
Belgium	5 5	5 7	9 8	6 3	6 6	11 6
Bulgaria						
Czechoslovakia						
Denmark	4 9	6 1	8 7†	6 0	7 1	9 5†
Finland						
France	6 1	7 6‡	9 7	6 9	8 7‡	13 8
East Germany						
West Germany		4 4	8 9§		5 3	9 6§
Greece						
Hungary						
Ireland						
Italy						
Netherlands						
Norway						
Poland						
Portugal	4 4‖	5 2	5 7	4 9‖	6 2	8 1
Rumania						
Spain						
Sweden	3 9	7 6	9 7	5 6	9 1	10 9
Switzerland	5 1‖	5 4	8 5	5 1‖	6 2	10 6
United Kingdom ††	4 3	4 2	9 3‡‡	5 0	5 2	12 3‡‡
England and Wales						
Northern Ireland						
Scotland						
Yugoslavia						
U.S.S.R.						
Australia		4 4§§	7 4		4 2§§	8 6
Canada		5 1	7 8		5 0	7 7
New Zealand		4 7	9 1		3 3	10 1
United States		4 0	7 8		4 1	8 5
Brazil						
Mexico		2 1‖‖	2 3		2 1‖‖	2 7
Egypt						
India		2 3§§	3 4¶¶		2 5§§	3 8¶¶

* Source United Nations, Department of Economic and Social Affairs, *The Aging of Population and Its Economic and Social Implications* (New York 1956) Table 7

† From United Nations *Demographic Yearbook 1956*

‡ Excluding non-declared and those 95 and over

§ Data for Federal Republic

‖ 1860

¶ Comparability after 1901 affected by territorial changes

** 1855

†† Great Britain

‡‡ Based on 1 per cent sample.

§§ 1910

‖‖ Excluding Federal District and Indian population

¶¶ Based on 10 per cent sample

TABLE 3*

Expectation of Life at Specified Ages for Each Sex
(In Years)

Country	Period	Male				Female			
		0	60	65	70	0	60	65	70
Austria	1949–51	61 9	15 1	12 0	9 3	67 0	17 3	13 6	10 4
Belgium	1946–49	62 0	15 4	12 3	9 5	67 3	17 4	13 9	10 7
Bulgaria	1925–28	45 9	16 4	13 5	10 9	46 6	17 2	13 9	11 0
Czechoslovakia	1929–32	51 9	14 4	11 3	8 7	55 2	15 4	12 1	9 2
Denmark	1951–55	69 9	17 5	13 9	10 7	72 6	18 4	14 6	11 2
Finland	1951–55	63 4	14 1	11 2	8 7	69 8	16 9	13 2	10 0
France	1952–56	65 0	15 2	12 1	9 3	71 2	18 5	14 8	11 3
East Germany	*1954–55*	*66 2*	*16 3*	*13 0*	*10 0*	*70 2*	*18 2*	*14 3*	*10 8*
West Germany	1949–51	64 6	16 2	12 8	9 8	68 5	17 5	13 7	10 4
Greece	1926–30	49 1	16 0	13 1	10 6	50 9	17 5	14 1	11 0
Hungary	1955	64 7	15 9	12 6	9 6	68 7	17 5	13 8	10 6
Ireland	1950–52	64 5	15 4	12 1	9 2	67 1	16 8	13 3	10 2
Italy	1950–53	63 8	16 0	12 6	9 6	67 2	17 5	13 7	10 4
Netherlands	1953–55	71 0	17 8	14 1	10 8	73 9	18 9	15 0	11 5
Norway	1951–55	71 1	18 5	14 9	11 6	74 7	19 9	16 0	12 3
Poland	1952–53	58 6	14 7	11 7	9 1	64 2	17 3	13 7	10 6
Portugal	1955–56	58 8	14 8	11 6	8 7	63 8	17 6	13 8	10 3
Rumania									
Spain	1950	58 8	15 2	12 0	9 1	63 5	17 7	14 0	10 6
Sweden	1951–55	70 5	17 4	13 8	10 6	73 4	18 6	14 8	11 3
Switzerland	1948–53	66 4	15 7	12 4	9 5	70 8	17 8	14 0	10 7
United Kingdom									
England and Wales	1956	67 8	15 0	11 8	9 2	73 3	18 7	14 9	11 4
Northern Ireland	1954–56	67 4	15 5	12 3	9 5	71 0	17 6	14 0	10 7
Scotland	1955–57	65 9	14 5	11 6	9 0	71 1	17 5	13 8	10 6
Yugoslavia§	1952–54	59 2	14 9	11 8	9 0	63 5	17 0	13 4	10 3
U S S R	1955–56	63 0				69 0			
Australia	1953 55	67 1	15 5	12 3	9 6	72 8	18 8	15 0	11 6
Canada	1950–52	66 3	16 5	13 3	10 4	70 8	18 6	15 0	11 6
New Zealand†	*1950–52*	*68 3*	*16 2*	*12 9*	*10 0*	*72 4*	*18 5*	*14 8*	*11 5*
United States‡	1956	67 3	15 9	12 9	10 3	73 7	19 3	15 5	12 2
Brazil‖	1890–1920	39 2	13 0	10 6	8 5				
Mexico	1940	37 9	13 4	10 9	8 7	39 8	13 5	10 9	8 5
Egypt	1936–38	35 6	13 3	10 5	7 9	41 5	16 3	12 8	9 6
India	*1941–50*	*32 4*	*10 1*	*8 2*	*6 5*	*31 7*	*11 3*	9 3	7 3

* Source *United Nations Demographic Yearbook 1958* Table 31

† European population only

‡ White population only

§ *Croatia*

‖ Data for both sexes

TABLE 4*

Specific Death Rates by Age for Males

Country	Year of Data	Age: All Ages	50–54	55–59	60–64	65–69	70–74	75–79	80–84	85 and Over
Austria	1953	13 1	11 2	17 3	26 9	43 3	62 5	102 2	161 6	264 0
Belgium	1953	13 1	11 1	17 8	26 2	38 9	59 9	98 4	156 7	248 6
Bulgaria	1945	16 7					38 4			
Czechoslovakia										
Denmark	1954	9 4	7 6	11 8	19 6	29 8	50 0	82 0	137 7	243 1
Finland	1953	10 3	13 7	22 8	32 7	51 9	77 1	120 6	178 9	283 8
France	1953	13 6	12 4	18 5	26 7	41 0	64 1	106 4	169 8	302 1
East Germany										
West Germany	1953	12 0	9 9	15 8	24 3	38 3	63 2	105 7	169 9	277 7
Greece										
Hungary†	1953	11 7	11 3		29 3			105 5		
Ireland	1951	14 9	11 7	17 7	28 0	43 1	71 3	118 6	196 1	294 5
Italy	1951	11 0	10 6	15 5	22 8	35 1	58 5	99 4	159 2	301 8
Netherlands	1953	8 0	6 9	11 3	17 5	27 9	47 9	80 9	131 9	233 5
Norway	1953	8 7	6 6	10 3	16 4	26 3	43 9	67 9	114 4	218 3
Poland										
Portugal	1954	11 5	11 1	16 3	25 5	38 9	66 2	111 9	203 7	
Rumania										
Spain	1950	11 6	9 8	21 5				74 3		
Sweden	1953	9 9	6 7	11 9	18 6	30 0	48 8	82 1	136 1	245 7
Switzerland	1953	10 8	9 7	15 2	24 4	38 3	60 2	96 6	162 0	264 5
United Kingdom										
England and Wales	1953	12 2	10 3	17 2	28 1	43 9	66 7	105 1	162 4	238 1
Northern Ireland	1954	11 5	10 3	16 3	25 5	41 0	68 4	89 2	145 2	280 0
Scotland	1954	12 9	12 6	21 1	32 0	46 5	69 3	110 3	169 7	274 5
Yugoslavia	1953	12 8	11 8	18 6	29 2	46 1	70 1	113 4	185 7	332 4
U S S R										
Australia	1953	10 0	10 5	17 2	27 4	40 7	63 3	98 7	144 7	279 2
Canada	1953	9 8	10 4	15 7	24 2	35 3	53 6	82 4	129 3	231 9
New Zealand	1954	10 0	8 4	14 1	25 8	37 5	56 1	88 0	138 1	229 4
United States	1953	11 1	12 9	19 4	29 2	42 6	58 2	89 8	132 5	195 8
Brazil	1950	14 5		26 4		51 8		100 6	196 8	
Mexico	1950	17 3	17 6	23 8	31 7	44 5	66 0	89 8	119 4	229 2
Egypt										
India	1947	23 5	20 3	22 1	30 3	50 2	70 7	134 2	183 6	664 8

* Source United Nations *Demographic Yearbook* 1955 Table 27

† Data are given for both sexes together with specific death rates by age for males

TABLE 3*

EXPECTATION OF LIFE AT SPECIFIED AGES FOR EACH SEX
(In Years)

COUNTRY	PERIOD	MALE				FEMALE			
		0	60	65	70	0	60	65	70
Austria	1949–51	61 9	15 1	12 0	9 3	67 0	17 3	13 6	10 4
Belgium	1946–49	62 0	15 4	12 3	9 5	67 3	17 4	13 9	10 7
Bulgaria	1925–28	45 9	16 4	13 5	10 9	46 6	17 2	13 9	11 0
Czechoslovakia	1929–32	51 9	14 4	11 3	8 7	55 2	15 4	12 1	9 2
Denmark	1951–55	69 9	17 5	13 9	10 7	72 6	18 4	14 6	11 2
Finland	1951–55	63 4	14 1	11 2	8 7	69 8	16 9	13 2	10 0
France	1952 56	65 0	15 2	12 1	9 3	71 2	18 5	14 8	11 3
East Germany	*1954–55*	*66 2*	*16 3*	*13 0*	*10 0*	*70 2*	*18 2*	*14 3*	*10 8*
West Germany	1949–51	64 6	16 2	12 8	9 8	68 5	17 5	13 7	10 4
Greece	*1926–30*	*49 1*	*16 0*	*13 1*	*10 6*	50 9	17 5	14 1	11 0
Hungary	1955	64 7	15 9	12 6	9 6	68 7	17 5	13 8	10 6
Ireland	1950–52	64 5	15 4	12 1	9 2	67 1	16 8	13 3	10 2
Italy	*1950–53*	*63 8*	*16 0*	*12 6*	*9 6*	*67 2*	*17 5*	13 7	10 4
Netherlands	1953–55	71 0	17 8	14 1	10 8	73 9	18 9	15 0	11 5
Norway	1951–55	71 1	18 5	14 9	11 6	74 7	19 9	16 0	12 3
Poland	1952–53	58 6	14 7	11 7	9 1	64 2	17 3	13 7	10 6
Portugal	1955–56	58 8	14 8	11 6	8 7	63 8	17 6	13 8	10 3
Rumania									
Spain	1950	58 8	15 2	12 0	9 1	63 5	17 7	14 0	10 6
Sweden	1951–55	70 5	17 4	13 8	10 6	73 4	18 6	14 8	11 3
Switzerland	1948–53	66 4	15 7	12 4	9 5	70 8	17 8	14 0	10 7
United Kingdom									
England and Wales	1956	67 8	15 0	11 8	9 2	73 3	18 7	14 9	11 4
Northern Ireland	*1954–56*	*67 4*	*15 5*	*12 3*	*9 5*	*71 0*	17 6	*14 0*	10 7
Scotland	1955 57	65 9	14 5	11 6	9 0	71 1	17 5	13 8	10 6
Yugoslavia§	1952–54	59 2	14 9	11 8	9 0	63 5	17 0	13 4	10 3
U S S R	1955–56	63 0				69 0			
Australia	1953 55	67 1	15 5	12 3	9 6	72 8	18 8	15 0	11 6
Canada	1950–52	66 3	16 5	13 3	10 4	70 8	18 6	15 0	11 6
New Zealand†	1950–52	68 3	16 2	12 9	10 0	72 4	18 5	14 8	11 5
United States‡	1956	67 3	15 9	12 9	10 3	73 7	19 3	15 5	12 2
Brazil‖	1890–1920	39 2	13 0	10 6	8 5				
Mexico	1940	37 9	13 4	10 9	8 7	39 8	13 5	10 9	8 5
Egypt	1936–38	35 6	13 3	10 5	7 9	41 5	16 3	12 8	9 6
India	1941–50	32 4	10 1	8 2	6 5	31 7	11 3	9 3	7 5

* Source *United Nations Demographic Yearbook 1957* Table 31

† European population only

‡ White population only

§ Croatia

‖ Data for both sexes

TABLE 6*

Death Rates by Marital Status for Males 65 and Over

Country	Year of Data	Single No	Single Per Cent	Married No	Married Per Cent	Widowed No	Widowed Per Cent	Divorced No	Divorced Per Cent
Austria									
Belgium	1950	3,154		15,951		12,279		286	
Bulgaria									
Czechoslovakia									
Denmark	1955	958		6,674		4,867		268	
Finland	1950	1,070	11 6	4,569	7 2	2,978	11 3	101	11 2
France	1954	11,293	8 8	82,547	6 0	54,499	11 5	1,514	6 8
East Germany	1956	1,537		38,403		23,567		901	
West Germany	1950	7,177	6 9	74,084	5 5	49,793	9 6	1,412	8 9
Greete									
Hungary									
Ireland	1955	3 853		5,129		4,056			
Italy									
Netherlands									
Norway	1950	1,035	6 4	4 344	5 0	3,679†	9 6†		
Poland									
Portugal	1950	1,638	8 9	9,351	6 1	6,274	10 8	76	6 9
Rumania									
Spain									
Sweden	1950	3 174	7 3	10,113	5 2	9,410†	9 8†		
Switzerland									
United Kingdom									
England and Wales	1951	14,299	8 8	90,551	6 9	63,087†	12 6†		
Northern Ireland	1956	979		2,175		1,607			
Scotland	1951	2,557	9 5	9,048	7 3	7,479	12 1	28	9 2
Yugoslavia									
U.S.S.R.									
Australia	1954	3,463	9 1	13,657	6 1	7,617	10 8	192	6 6
Canada									
New Zealand‡	1956	785		3,523		2,022		72	
United States	1950	40 771	8 5	214,981	5 7	135,189	9 8	10,240	9 6
Brazil									
Mexico									
Egypt									
India									

* Source *United Nations Demographic Yearbook 1958* Tables 13 and 6

† Includes divorced

‡ European population only

TABLE 5*

SPECIFIC DEATH RATES BY AGE FOR FEMALES

COUNTRY	YEAR OF DATA	AGE: All Ages	50–54	55–59	60–64	65–69	70–74	75–79	80–84	85 and Over
Austria	1953	11 0	6 3	9 4	15 5	26 6	48 5	83 8	137 8	218 4
Belgium	1953	11 1	5 8	9 2	15 3	26 6	45 5	79 0	127 4	215 8
Bulgaria	1945	13 0					32 0			
Czechoslovakia										
Denmark	1954	8 7	5 4	8 7	13 8	24 6	43 7	76 7	130 1	233 4
Finland	1953	9 0	6 6	10 7	17 6	31 4	54 6	96 6	151 5	285 9
France	1953	12 4	6 8	9 7	14 7	23 9	42 0	74 0	126 5	232 4
East Germany										
West Germany	1953	10 1	6 0	9 5	15 6	28 4	51 8	92 8	152 8	252 9
Greece										
Hungary†	1953	11 7								
Ireland	1951	13 7	9 5	13 7	22 3	36 1	60 3	104 6	171 7	257 3
Italy	1951	9 7	6 2	9 7	15 8	27 7	48 5	88 8	137 8	271 2
Netherlands	1953	7 3	5 4	8 2	13 4	23 5	41 8	74 8	122 5	218 0
Norway	1953	8 2	4 4	7 2	10 8	19 5	34 6	60 5	105 4	211 9
Poland										
Portugal	1954	10 4	6 1	9 1	15 0	24 9	44 4	81 8	185 8	
Rumania										
Spain	1950	10 2	5 9	12 9				62 4		
Sweden	1953	9 5	5 5	8 6	13 9	24 2	43 7	74 4	129 0	230 0
Switzerland	1953	9 6	6 0	8 9	14 4	25 8	44 7	80 7	133 9	244 1
United Kingdom										
England and Wales	1953	10 7	5 8	9 0	14 6	24 4	41 7	74 1	122 8	218 8
Northern Ireland	1954	10 4	7 3	10 6	18 0	27 3	52 4	72 0	141 1	244 2
Scotland	1954	11 2	7 5	10 6	18 7	28 9	48 7	82 8	143 6	233 9
Yugoslavia	1953	12 1	8 5	13 3	22 2	36 5	61 1	101 4	173 7	310 0
U.S.S.R.										
Australia	1953	8 1	6 6	9 6	15 3	23 9	40 2	71 8	115 5	249 9
Canada	1953	7 4	6 4	9 5	15 4	24 3	39 9	67 6	111 0	208 8
New Zealand	1954	8 0	5 7	9 5	14 1	22 5	39 6	68 0	106 5	211 2
United States	1953	8 1	7 3	10 5	16 2	26 3	39 7	67 8	110 7	179 9
Brazil	1950	11 6	15 1		29 5		65 2		163 2	
Mexico	1950	15 2	13 1	18 1	26 5	41 1	60 1	88 5	121 8	260 6
Egypt	1947	19 6	12 7	11 0	18 0	31 5	45 7	100 2	141 7	723 0
India										

* Source *United Nations Demographic Yearbook 1955* Table 21

† Data for both sexes

TABLE 6*

Death Rates by Marital Status for Males 65 and Over

Country	Year of Data	Single		Married		Widowed		Divorced	
		No	Per Cent	No	Per Cent	No	Per Cent	No	Per Cent
Austria							•		
Belgium	1950	3,154		15,951		12,279		286	
Bulgaria									
Czechoslovakia							•		
Denmark	1955	958		6,674		4,867		268	
Finland	1950	1,070	11 6	4,569	7 2	2,978	11 3	101	11 2
France	1954	11,293	8 8	82,547	6 0	54,499	11 5	1,514	6 8
East Germany	1956	1,537		38,403		23,567		901	
West Germany	1950	7,177	6 9	74,084	5 5	49,793	9 6	1,412	8 9
Greece									
Hungary									
Ireland	1955	3 853		5,129		4,056			
Italy									
Netherlands									
Norway	1950	1 035	6 4	4,344	5 0	3,679†	9 6†		
Poland									
Portugal	1950	1,638	8 9	9,351	6 1	6,274	10 8	76	6 9
Rumania									
Spain									•
Sweden	1950	3,174	7 3	10,113	5 2	9,410†	9 8†		•
Switzerland									
United Kingdom									
England and Wales	1951	14,299	8 8	90,551	6 9	63,087†	12 6†		
Northern Ireland	1956	979		2,175		1,607			
Scotland	1951	2,557	9 5	9,048	7 3	7,479	12 1	28	9 2
Yugoslavia									
U.S.S.R.									
Australia	1954	3 463	9 1	13,657	6 1	7,617	10 8	192	6 6
Canada									
New Zealand‡	1956	785		3,523		2,022		72	
United States	1950	40 771	8 5	214,981	5 7	135,189	9 8	10,240	9 6
Brazil									
Mexico									
Egypt									
India									

* Source *United Nations Demographic Yearbook 1957* Tables 13 and 6
† Includes divorced
‡ European population only

TABLE 7*

Death Rates by Marital Status for Females 65 and Over

Country	Year of Data	Single		Married		Widowed		Divorced	
		No.	Per Cent	No.	Per Cent	No.	Per Cent	No.	Per Cent
Austria									
Belgium	1950	4,186		9,003		19,720		264	
Bulgaria									
Czechoslovakia									
Denmark	1955	1,904		3,407		7,038		302	
Finland	1950	1,657	6.4	2,038	5.0	7,702	7.9	138	6.8
France	1954	18,487	5.5	31,696	3.4	125,409	6.8	2,357	4.2
East Germany	1956	5,205		17,259		49,659		1,479	
West Germany	1950	14,103	5.5	36,954	4.5	93,941	7.1	1,515	6.7
Greece									
Hungary									
Ireland	1955	3,007		2,184		6,707			
Italy									
Netherlands									
Norway	1950	1,956	5.4	2,462	4.0	6,140†	7.9†		
Poland									
Portugal	1950	3,740	7.2	4,402	3.9	14,157	7.4	100	6.3
Rumania									
Spain									
Sweden	1950	5,059	6.3	5,996	4.5	13,716†	8.0†		
Switzerland									
United Kingdom									
England and Wales	1951	29,831	6.6	45,499	4.5	116,479†	8.3†		
Northern Ireland	1956	1,303		947		2,821		2	
Scotland	1951	4,682	7.4	4,673	5.3	12,537	9.1	44	9.3
Yugoslavia									
U.S.S.R.									
Australia	1954	3,339	6.0	5,761	3.9	13,999	7.0	114	4.2
Canada									
New Zealand‡	1956	759		1,512		3,360		34	
United States	1950	32,887	5.7	85,596	3.7	233,501	6.6	4,180	5.7
Brazil									
Mexico									
Egypt									
India									

* Source *United Nations Demographic Yearbook 1955*, Tables 13 and 6

† Includes divorced

‡ European population only

TABLE 8*

ECONOMICALLY ACTIVE POPULATION 65 AND OVER FOR BOTH SEXES

Country	Year of Data	Males 65 and Over			Females 65 and Over		
		Total Population	Economically Active		Total Population	Economically Active	
			No	Per Cent		No	Per Cent
Austria	1951	305,881	95,836	31 3	427,156	57,169	13 4
Belgium	1947	409,522	101,179	24 7	500,367	26,841	5 4
Bulgaria							
Czechoslovakia							
Denmark	1950	184,332	66,211	35 9	205,853	17,187	8 3
Finland	1950	99,675	56,489	56 7	166,851	34,331	20 6
France	1946	1,763,856	959,296	54 4	2,591,594	578,747	22 3
East Germany	1946	760,035	273,181	35 9	967,445	110,058	11 4
West Germany	1950	1,992,479	533,393	26 8	2,431,394	235,803	9 7
Greece	1951	225,349	138,743	61 6	284,809	14,080	4 9
Hungary	1949	305,705	189,364	61 9	387,152	75,560	19 5
Ireland	1951	155,038	90,517	58 4	161,353	27,356	17 0
Italy							
Netherlands	1947	325,844	115,675	35 5	357,295	22,648	6 3
Norway	1946	130,352	62,968	48 3	163,827	17,403	10 6
Poland							
Portugal	1950	231,747	155,815	67 2	357,768	43,592	12 2
Rumania							
Spain							
Sweden	1950	335,224	121,110	36 1	385,869	29,926	7 8
Switzerland	1950	194,058	98,414	50 7	259,168	30,726	11 9
United Kingdom	1951	2,174,800	695,300	32 0	3,125,200	166,000	5 3
England and Wales							
Northern Ireland	1951	60,748	23,918	39 4	74,245	5,554	7 5
Scotland	1951	214,704	74,601	34 7	292,191	13,508	4 6
Yugoslavia	1953	423,000	255,000	60 3	587,000	69,000	11 8
U.S.S.R.							
Australia	1947	279,809	94,775	33 9	325,088	15,968	4 9
Canada	1951	550,709	212,399	38 6	534,667	27,188	5 1
New Zealand	1951	84,613	22,461	26 5	92,846	3,074	3 3
United States	1950	5,734,250	2 379,545	41 5	6,522,600	507,345	7 8
Brazil	1950	329,187†	186,463	56 6	421,686†	19,462	4 6
Mexico	1950	412,603			453,011		
Egypt	1947	267,121	234,217	87 7	319,072	211,332	66 2
India							

* Source United Nations Demographic Yearbook 1956, Table 11

† Age 70 and over

TABLE 9*

ECONOMICALLY ACTIVE MALES ENGAGED IN AGRICULTURE†

Country	Year of Data	Economically Active Male Population: Total	Engaged in Agriculture: No	Engaged in Agriculture: Per Cent
Austria	1951	2,055,630	510,971	24.9
Belgium	1947	2,660,111	361,647	13.6
Bulgaria				
Czechoslovakia	1947	3,793,420	1,123,235	29.6
Denmark	1950	1,368,975	396,941	29.0
Finland	1950	1,176,053	542,724	46.1
France	1954	12,855,000	3,371,000	26.2
East Germany	1946	4,464,149	1,046,107	23.4
West Germany	1950	14,125,000	2,316,000	16.4
Greece	1951	2,328,901	1,152,292	49.5
Hungary	1949	2,950,228	1,544,656	52.4
Ireland	1951	947,190	436,172	46.0
Italy	1951	14,663,427	6,227,713	42.5
Netherlands	1947	2,892,392	578,500	20.0
Norway	1950	1,059,894	332,696	31.4
Poland				
Portugal	1950	2,551,389	1,329,641	52.1
Rumania				
Spain	1950	9,084,227	4,853,160	53.4
Sweden	1950	2,285,686	578,708	25.3
Switzerland	1950	1,515,232	325,321	21.5
United Kingdom	1951	15,662,200	997,500	6.4
England and Wales				
Northern Ireland	1951	420,790	92,897	22.1
Scotland	1951	1,585,335	150,435	9.5
Yugoslavia	1953	5,145,000	3,079,000	59.8
U.S.S.R.				
Australia	1947	2,479,269	473,581	19.1
Canada	1951	4,130,802	969,593	23.5
New Zealand	1951	568,963	126,220	22.2
United States	1950	43,542,293	6,719,975	15.4
Brazil	1950	14,609,798	9,154,034	62.7
Mexico‡	1950	8,345,240	4,823,901	57.8
Egypt	1947	7,058,302	3,685,532	52.2
India	1951	85,460,898	59,313,352	69.4

* Source: *United Nations Demographic Yearbook 1956*, Table 12

† Includes forestry, hunting, and fishing

‡ Data for both sexes.

TABLE 10*

NATIONAL AND PER CAPITA INCOME, 1949, IN NATIONAL CURRENCIES AND UNITED STATES DOLLARS

Country	Quality of Income Estimate	1949 National Income		1949 Income per Capita (U.S. Dollars)
		Unit	Amount	
Austria	O†	Million schillings	29,198	216
Belgium	O	Million francs	250,775	582
Bulgaria				
Czechoslovakia	E‡	Thousand million koruny	244	371
Denmark	O	Million kroner	16,480	689
Finland	O	Thousand million markkaa	323 2	349
France	O	Thousand million francs	6,930	482
East Germany				
West Germany	O	Thousand million Deutsche marks	64 5	320
Greece	O	Thousand million drachmae	19,200	128
Hungary	E	Million forints	24,875§	269
Ireland	E	Million pounds	342	420
Italy	O	Thousand million lire	6,192	235
Netherlands	O	Million guldens	14,135	502
Norway	O	Million kroner	9,640	587
Poland	O		¶	300
Portugal	C‖		¶	250
Rumania				
Spain				
Sweden	O	Million kronor	22,500	780
Switzerland	O	Million francs	16,940	849
United Kingdom	O	Million pounds	10,420	773
England and Wales				
Northern Ireland				
Scotland				
Yugoslavia	E	Thousand million dinars	191	146
U.S.S.R.	E		¶	308
Australia**	O	Million pounds	1,896	679
Canada	O	Million dollars	12,977	870
New Zealand††	O	Million pounds	473	856
United States	O	Million dollars	216,831	1,453
Brazil	E	Thousand million cruzeiros	170	112
Mexico	O	Million pesos	25,600	121
Egypt	E	Million pounds	650	100
India**	O	Million rupees	93,200	57

* Source United Nations, Department of Economic and Social Affairs, *National and Per Capita Incomes of Seventy Countries in 1949 Expressed in United States Dollars* (New York, 1950) Table 1

† Official or semiofficial estimate

‡ Estimate or extrapolation by the Statistical Office of the United Nations

§ Figure for 1949 not available: based on older estimate or on an assumed per capita income

‖ Crude estimate by the Statistical Office based on assumed per capita figure

¶ In prices of January 1947

** For 1948-49

†† For 1949-50

TABLE 11*

CHANGES IN THE COST-OF LIVING INDEX, 1948–58 (1953 = 100)

COUNTRY	YEAR 1948	YEAR 1958	PER CENT INCREASE
Austria	50	114	128.0
Belgium	95	108	13.7
Bulgaria	.		
Czechoslovakia	.		
Denmark	81	117	44.4
Finland	64	128	100.0
France	60	121	101.7
East Germany	..		
West Germany	93	110	18.3
Greece	63	131	107.9
Hungary	..		
Ireland	79	117	48.1
Italy	86	113	31.4
Netherlands	77	117	51.9
Norway	74	117	58.1
Poland			
Portugal	96	105	9.4
Rumania			
Spain	79	140	77.2
Sweden	77	119	54.5
Switzerland	96	107	11.5
United Kingdom	77	119	54.5
England and Wales			
Northern Ireland			
Scotland			
Yugoslavia		125	
U S S R			
Australia	56	115	105.4
Canada	84	108	28.6
New Zealand	75	119	58.7
United States	90	108	20.0
Brazil	62	238	283.9
Mexico	71	150	111.3
Egypt	93	102	7.4
India	92	109	18.5

* Source *International Financial Statistics* Vol 10, No 10 and Vol 12, No 10

TABLE 12*

CIRCULATION OF DAILY NEWSPAPERS AND PER CAPITA NEWSPRINT CONSUMPTION

COUNTRY	CIRCULATION OF DAILY NEWSPAPERS		NEWSPRINT CONSUMPTION PER CAPITA, 1957 (IN KILOGRAMS)
	Year	Per 1000 Population	
Austria	1956	187	6.5
Belgium	1952	383	9.5†
Bulgaria	1956	170	2.4
Czechoslovakia	1956	170	
Denmark	1955	376	15.5
Finland	1956	420	18.1
France	1956	244	10.7
East Germany	1954	118	8.0‡
West Germany	1956	277	
Greece	1952	71	1.8
Hungary	1956	122	
Ireland	1955	269	10.3
Italy	1952	107	4.4
Netherlands	1956	264	11.3
Norway	1956	374	11.0
Poland	1956	150	1.7
Portugal	1954	61	3.1
Rumania	1957	149	1.7
Spain	1956	68	1.9
Sweden	1956	462	24.8
Switzerland	1956	296	12.7
United Kingdom	1954	573	20.0
England and Wales			
Northern Ireland			
Scotland			
Yugoslavia	1956	48	1.5
U.S.S.R	1956	107	1.6
Australia	1957	381	27.2
Canada	1956	244	25.1
New Zealand	1956	390	28.4
United States	1956	337	36.3
Brazil	1955	50	
Mexico	1952	48	
Egypt	1952	25	0.8
India	1953	7	0.2

* Source *United Nations Statistical Yearbook 1958* Tables 180 and 181

† Belgium and Luxembourg

‡ Figure combined for West Germany and East Germany

TABLE 13*

NUMBER OF RADIO RECEIVERS AND RECEIVERS PER 1000 POPULATION

Country	Year of Data	No. of Receivers (in Thousands)	No. of Receivers per 1000 Population
Austria	1957	1,838	263
Belgium	1957	2,307	257
Bulgaria	1956	400	53
Czechoslovakia	1957	3,323	249
Denmark	1957	1,551	345
Finland	1957	1,121	239
France	1957	10,881	247
East Germany	1957	5,397	329
West Germany	1957	14,634	284
Greece	1957	545	67
Hungary	1956	1,774	180
Ireland	1957	477	165
Italy	1957	6,759	139
Netherlands	1957	3,128	284
Norway	1957	985	282
Poland	1957	4,028	142
Portugal	1957	596	67
Rumania	1957	1,499	84
Spain	1957	2,105	72
Sweden	1957	2,695	368
Switzerland	1957	1,308	256
United Kingdom	1957	14,654	284
England and Wales			
Northern Ireland			
Scotland			
Yugoslavia	1957	890	49
U.S.S.R.	1956	29,571	148
Australia	1956	2,089	222
Canada	1956	9,050	563
New Zealand	1957	531	238
United States	1956	150,000	892
Brazil	1954	3,500	61
Mexico	1955	2,500	84
Egypt	1956	850	36
India	1956	1,076	3

TABLE 14*

ANNUAL PER CAPITA ATTENDANCE AT CINEMAS

Country	Year of Data	Per Capita Attendance
Austria	1955	15.8
Belgium	1957	11.5
Bulgaria	1957	10.1
Czechoslovakia	1957	13.9
Denmark	1956	11.7
Finland	1957	7.4
France	1957	9.7
East Germany	1955	17.2
West Germany	1956	15.4
Greece		
Hungary	1956	11.5
Ireland	1957	18.0
Italy	1954	16.8
Netherlands	1957	5.9
Norway	1957	10.0
Poland	1957	8.2
Portugal	1957	3.1
Rumania	1957	4.9
Spain	1954	10.4
Sweden	1958	9.4
Switzerland	1957	7.2
United Kingdom	1957	17.8
England and Wales		
Northern Ireland		
Scotland		
Yugoslavia	1957	6.0
U.S.S.R.	1957	15.1
Australia	1956	14.5
Canada	1957	10.6
New Zealand	1957	16.9
United States	1957	14.0
Brazil	1955	5.3
Mexico	1957	8.5
Egypt	1955	2.7
India	1953	2.0

* Source: *United Nations Statistical Yearbook 1958*, Table 183B

TABLE 15*

ESTIMATED PER CAPITA CONSUMPTION OF COMMERCIAL SOURCES OF ENERGY 1937 AND 1956

(Expressed in Coal Equivalents in Metric Tons)

Country	1937	1956
Austria	1 04	2 43
Belgium Luxembourg	4 02	4 34
Bulgaria	0 14	0 60
Czechoslovakia	1 78	3 98
Denmark	1 71	2 62
Finland	1 03	1 89
France	2 12	2 68
[illegible]		3 66
[illegible]		3 60
[illegible]	.	0 36
Hungary	0 72	1 52
Ireland	1 10	1 39
Italy	0 66	1 12
Netherlands	1 79	2 45
Norway	3 44	5 66
Poland	0 75	2 74
Portugal	0 24	0 42
Rumania	0 37	1 28
Spain	0 40	0 88
Sweden	2 50	4 59
Switzerland	1 81	3 18
United Kingdom	4 24	5 03
England and Wales		
Northern Ireland		
Scotland		
Yugoslavia	0 18	0 58
U.S.S.R	0 87	2 45
Australia	2 27	3 85
Canada†	4 91	8 25
New Zealand	1 94	2 81
United States	5 89	8 58
Brazil	0 13	0 39
Mexico	0 44	0 75
India	0 09‡	0 12
Egypt	0 13	0 24

* Source United Nations Statistical Yearbook 1957 Table 128

† Including Newfoundland

‡ Including area now Pakistan

Contributors

JOHN E ANDERSON, PH.D
Professor, Institute of Child Welfare, University of Minnesota, Minneapolis, Minnesota

JOHN C BEAVAN
Assistant Director, Nuffield Foundation, London, England

ERNEST W BURGESS PH D
Professor Emeritus of Sociology, University of Chicago, Chicago Illinois

WILBUR J COHEN
Professor of Public Welfare Administration, School of Social Work, University of Michigan, Ann Arbor Michigan

WILMA DONAHUE, PH D
Chairman, Division of Gerontology, Institute for Human Adjustment, University of Michigan Ann Arbor, Michigan

LUDWIG VON FRIEDEBURG
Institut fur Sozialforschung an der Johann Wolfgang Goethe Universitat, Frankfurt am Main Germany

PHILIP M HAUSER, PH.D
Professor of Sociology, University of Chicago Chicago, Illinois

ROBERT J HAVIGHURST, PH.D
Professor of Education University of Chicago, Chicago, Illinois

BERTHA JAMES
Chairman, Northwest Kent Old People s Welfare Committee, and Chairman, Homes, Housing and Home Services Committee of the National Old People s Welfare Council, England

MARGRIT KESSI
School of Social Work, Zurich, Switzerland

ROBERT W KLEEMEIER, PH.D
Research Professor, Department of Psychology, Washington University, St Louis, Missouri

JEROME S PETERSON, M D
Director, Division of Organization of Public Health Services, World Health Organization, Geneva, Switzerland

VERA J PETERSON, M D
Honorary Secretary, Medical Women's International Association, Geneva, Switzerland

MAX RHEINSTEIN, J U D
Max Pam Professor of Law, University of Chicago, Chicago, Illinois

HELEN L SLATER
Secretary, Exeter Council of Social Service, Exeter, England

JEAN RENÉ TRÉANTON, PH D
Centre d'Études Sociologiques, Centre National de la Recherche Scientifique, Paris, France

ROBERT J VAN ZONNEVELD, M D
National Health Research Council, TNO, The Hague, Netherlands

RAUL VARGAS, M.P.H
Statistician, World Health Organization, Buenos Aires, Brazil

SEYMOUR L WOLFBEIN, PH.D
Deputy Assistant Secretary of Labor, Department of Labor, Washington, D C

ANGELA ZUCCINO
Dean, School of Social Work, Rome, Italy

Indexes

Index of Names

Index of Subjects

[Page numbers followed by (c), (f), or (t) indicate that the reference is to a chart figure, or table]

Index of Subjects

[Page numbers followed by (c), (f), or (t) indicate that the reference is to a chart, figure, or table]

PRINTED IN U S A